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ADELAIDE, THURSDAY, 23 MAY 2013

WORKERS REHABILITATION AND COMPENSATION ACT 1986

Scales of charges for medical practitioners, medical and other charges

Preamble

Section 32(11)(a) of the *Workers Rehabilitation and Compensation Act 1986* (the Act), provides that the Minister for Industrial Relations may, by notice in the *Gazette*, on the recommendation of the Corporation, publish "scales of charges for the purpose 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 section 32(11)(a) of the Act, I publish the following scales of charges to have effect on and from 1 July 2013 and which supersede the scales of charges previously published in the *Government Gazette* on 24 May 2012:

1. scales of charges set out in Schedules 1A and 1B for the provision of medical and related or supplementary services by legally qualified medical practitioners;
2. scale of charges set out in Schedule 2 for the provision of services by chiropractors;
3. scale of charges set out in Schedule 3 for the provision of services by occupational therapists;
4. scale of charges set out in Schedule 4 for the provision of services by osteopaths;
5. scale of charges set out in Schedule 5 for the provision of services by physiotherapists;
6. scale of charges set out in Schedule 6 for the provision of services by psychologists;
7. scale of charges set out in Schedule 7 for the provision of services by speech pathologists;
8. scales of charges set out in Schedule 8 for the provision of services in private hospitals and day surgery facilities;
9. 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* and applicable as at 1 July 2013 and as amended from time to time.

INTERPRETATION

10. In this notice and the Schedules hereto —

Act means the *Workers Rehabilitation and Compensation Act 1986* (as amended);

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 *WorkCover Corporation 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 WorkCover by notice in the *Gazette* to be a day surgery facility;

DF or derived fee, for an item in Schedule 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;

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);

permanent impairment assessor means a person registered as a legally qualified medical practitioner who holds a current accreditation issued by WorkCover to undertake permanent impairment assessments pursuant to Section 43A of the Act.

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 WorkCover as a self-insured employer according to Part 5 Division 1 of the Act; and

WorkCover or ***Corporation*** means WorkCover Corporation of South Australia.

11. A reference in this notice to any guidelines is, unless indicated otherwise, a reference to the guidelines named and issued by WorkCover from time to time.

12. 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.

13. 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

14. 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 increased so that after deduction of the GST in relation to the service the amount of the fee remaining is equal to the maximum fee set out in, or determined in accordance with, the scale of charges.

15. 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.

HON JOHN RAU MP
Minister for Industrial Relations
Dated 14 May 2013.

SCHEDULE 1A—SCALE OF CHARGES—CLINICAL MEDICAL SERVICES

This schedule must be read in conjunction with the Medical Schedule 1A Guidelines.

Item no.	Description	Max fee (excl GST)

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

Level A

00003	Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management - each attendance	$22.80
00004	Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this table applies) that requires a short patient history and, if necessary, limited examination and management - an attendance on 1 or more patients at 1 place on 1 occasion - each patient Derived fee: The fee for Item 3 ($22.80), plus $41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $2.30 per patient.	DF
00020	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient Derived fee: The fee for Item 3 ($22.80), plus $74.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $2.30 per patient.	DF

Level B

00023	Professional attendance by a general practitioner at consulting rooms (not being a service to which any other item in this table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation each attendance	$65.80
00024	Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - an attendance on 1 or more patients at 1 place on 1 occasion - each patient	DF

Derived fee: The fee for Item 23 minus $6.60 ($59.20), plus $41.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 minus $6.60 ($59.20) plus $2.30 per patient.

00035 Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient — DF

Derived fee: The fee for Item 23 minus $6.60 ($59.20), plus $74.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 minus $6.60 ($59.20) plus $2.30 per patient.

Level C

00036 Professional attendance by a general practitioner at consulting rooms (not being a service to which any other item in this table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation each attendance — $98.60

00037 Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 place on 1 occasion - each patient — DF

Derived fee: The fee for Item 36 minus $3.90 ($94.70), plus $41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 minus $3.90 ($94.70) plus $2.30 per patient.

00043 Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient — DF

Derived fee: The fee for Item 36 minus $3.90 ($94.70), plus $74.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 minus $3.90 ($94.70) plus $2.30 per patient.

Level D

00044 Professional attendance by a general practitioner at consulting rooms (not being a service to which any other item in this table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - each attendance — $148.30

00047	Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation an attendance on 1 or more patients at 1 place on 1 occasion - each patient Derived fee: The fee for Item 44 ($148.30), plus $41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $2.30 per patient.	DF
00051	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient Derived fee: The fee for Item 44 ($148.30), plus $74.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $2.30 per patient.	DF

GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

00099	Professional attendance on a patient by a specialist practising in his or her specialty if:(a) the attendance is by video conference; and(b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and(d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item.	DF
00104	Professional attendance by a specialist in the practice of his or her speciality where the patient is referred to him or her an attendance (other than a second or subsequent attendance in a single course of treatment) 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	$139.30
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 hospital Note 1: Item number 0104A is not to be charged for independent medical examinations. Refer to Schedule 1B 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	$178.40

- 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.

00105	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her each attendance subsequent to the first in a single course of treatment where that attendance is at consulting rooms, hospital or residential aged care facility	$78.60
00106	- initial specialist ophthalmologist attendance, referred consultation in a single course of treatment, being an attendance at which the sole service provided is refraction testing for the issue of a prescription for spectacles or contact lenses not being a service to which items 104, 109 or 10801 to 10816 apply	$124.40
00107	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her an attendance (other than a second or subsequent attendance in a single course of treatment) where that attendance is at a place other than consulting rooms or hospital	$164.00
00108	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her each attendance subsequent to the first in a single course of treatment where that attendance is at a place other than consulting rooms or hospital or residential aged care facility	$106.00
00109	Initial specialist ophthalmologist paediatric attendance referred consultation in a single course of treatment, being an attendance at which a comprehensive eye examination, including pupil dilation, is performed on a child aged 9 years or under, or on a child aged 14 years or under with developmental delay, not being a service to which item 104, 106 or any of items 10801 to 10816 applies	$200.00
00113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment.	$96.30

GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

00110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner – initial attendance in a single course of treatment	$232.10
00112	Professional attendance on a patient by a consultant physician practising in his or her specialty if: the attendance is by video conference; and the attendance is for a service: provided with item 110 lasting more than 10 minutes; or provided with item 116, 119, 132 or 133; and the patient is not an admitted patient; and the patient: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the physician; or is a care recipient in a residential care service; or is a patient of: an aboriginal medical service; or an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item.	DF
00114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a	$169.80

	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.	
00116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a medical practitioner - each attendance (not being a service to which item 119applies) subsequent to the first in a single course of treatment	$119.40
00119	Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each minor attendance subsequent to the first in a single course of treatment	$61.50
00122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a referring practitioner initial attendance in a single course of treatment	$259.30
00128	Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each attendance (other than a service to which item 131 applies) subsequent to the first in a single course of treatment	$148.90
00131	Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each minor attendance subsequent to the first in a single course of treatment	$116.20
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 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. Note 1: 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.	$329.80
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.	$172.50

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.

Note 1: 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.

GROUP A29 - EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY

00135	Consultant paediatrician, referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder - surgery or hospital professional attendance of at least 45 minutes duration at consulting rooms or hospital, by a consultant physician in his or her specialty of paediatrics, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant paediatrician by a referring practitioner, if the consultant paediatrician does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 137, 139 or 289.	$329.80
00137	Specialist or consultant physician, referred consultation for assessment, diagnosis and development of a treatment and management plan for a child with an eligible disability - surgery or hospital professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.	$329.80
00139	General practitioner consultation for assessment, diagnosis and development of a treatment and management plan for a child with an eligible disability professional attendance of at least 45 minutes duration, at consulting rooms, by a general practitioner, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, if the general practitioner does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom	$202.10

payment has previously been made under this item or items 135, 137 or 289.

GROUP A28 - CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE

00141	Professional attendance at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, where 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, where the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan.an attendance of more than 60 minutes at consulting rooms or hospital during which: the medical, physical, psychological and social aspects of the patient's health are evaluated in detail, utilising appropriately validated assessment tools where indicated ('assessment'),the patient's various health problems and care needs are identified and prioritised ('formulation'),a detailed management plan is developed ('management plan'),the management plan is explained and discussed with the patient and/or their family and carer(s) where appropriate, and the management plan is communicated in writing to the referring practitioner. the management plan should include: the prioritised list of health problems and care needs, short and longer term management goals, recommended actions or intervention strategies to be undertaken by the patient's general practitioner or other relevant health care providers that are: likely to improve or maintain health status, readily available, and acceptable to the patient, their family and carer(s). not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner. not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item or item 145 by the same practitioner.	$518.80
00143	Professional attendance at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist in geriatric medicine and claimed under item 141 or 145, where the review is initiated by the referring medical practitioner practising in general practice or participating practice nurse. an attendance of more than 30 minutes duration at consulting rooms or hospital where that attendance follows item 141 or 145 and during which: the patient's health status is reassessed, a management plan provided under items 141 or 145 is reviewed and revised, the revised management plan is explained to the patient and/or their family and carer(s) and communicated in writing to the referring practitioner. not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner. being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under items 141 or 145 by the same practitioner, payable no more than once in any 12 month period, except for where there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.	$324.20
00145	Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, where the patient is at least 65 years old and has been referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or participating nurse practitioner, where the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan.an attendance of more than 60 minutes at a place other than consulting rooms or hospital during which: the medical, physical, psychological and social aspects of the patient's health are evaluated in detail, utilising appropriately validated assessment tools where indicated ('assessment'),the patient's various health problems and care needs are identified and prioritised ('formulation'),a detailed management plan is developed ('management plan'),the management plan is explained and discussed with the patient and/or their family and carer(s) where appropriate, the management plan is communicated in writing to the referring practitioner. the management plan should include: the prioritised list of health problems and care needs, short and longer term management goals, recommended actions or intervention strategies to be undertaken by the patient's general	$628.90

practitioner or other relevant health care providers that are: likely to improve or maintain health status readily available acceptable to the patient, their family and carer(s)not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner. not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item or 141 by the same practitioner.

00147	Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist in geriatric medicine and claimed under items 141 or 145, where the review is initiated by the referring medical practitioner practising in general practice or participating practice nurse. an attendance of more than 30 minutes duration at a place other than consulting rooms or hospital where that attendance follows items 141 or 145 and during which: the patient's health status is reassessed, a management plan provided under items 141 or 145 is reviewed and revised, the revised management plan is explained to the patient and/or their family and carer(s) and communicated in writing to the referring practitioner. not being an attendance on a patient in respect of whom, an attendance under items 104, 105, 107, 108, 110, 116 and 119 has been received on the same day by the same practitioner. being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under items 141 or 145 by the same practitioner, payable no more than once in any 12 month period, except for where there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.	$393.10
00149	Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; or (b) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item.	DF

GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

00160	Professional attendance for a period of not less than 1 hour but less than 2 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$301.00
00161	Professional attendance for a period of not less than 2 hours but less than 3 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$485.90
00162	Professional attendance for a period of not less than 3 hours but less than 4 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$656.50
00163	Professional attendance for a period of not less than 4 hours but less than 5 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$816.90
00164	Professional attendance for a period of 5 hours or more (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$966.70

GROUP A6 - GROUP THERAPY

00170	Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving	$205.40

	members of a family and persons with close personal relationships with that family each group of 2 patients	
00171	Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family each group of 3 patients	$211.10
00172	Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family each group of 4 or more patients	$242.70

GROUP A7 - ACUPUNCTURE

00173	Attendance at which acupuncture is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed.	$43.20
00193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care;for 1 or more health- related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	$61.10
00195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on 1 or more patients at a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care;for 1 or more health- related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed. Derived fee: The fee for Item 193 ($61.10), plus $41.60 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 193 plus $2.40 per patient.	DF
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 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	$97.30
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 1 or more health-	$162.90

related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.

GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

00288	Professional attendance on a patient by a consultant physician practising in his or her specialty of psychiatry if: the attendance is by video conference; and item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and the patient is not an admitted patient; and the patient: is located both: within a telehealth eligible area; and at the time of the attendance - at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: an aboriginal medical service; or an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for item 291, 293,296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352.	DF
00289	Consultant psychiatrist, referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder - surgery or hospital professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a consultant physician in his or her specialty of psychiatry, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant psychiatrist by a referring practitioner, if the consultant psychiatrist does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 137 or 139.	$410.70
00291	Consultant psychiatrist, referred patient assessment and management Professional attendance by a consultant physician in the practice of his or her speciality of psychiatry where the patient is referred for the provision of an assessment and management plan by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or participating nurse practitioner, where the attendance is initiated by the referring practitioner and where the consultant psychiatrist provides the referring medical practitioner with an assessment and management plan to be undertaken by that practitioner for the patient, where clinically appropriate. An attendance of more than 45 minutes duration at consulting rooms during which: - An outcome tool is used where clinically appropriate - a mental state examination is conducted - a psychiatric diagnosis is made - The consultant psychiatrist decides that the patient can be appropriately managed by the referring practitioner without the need for ongoing treatment by the psychiatrist - a 12 month management plan, appropriate to the diagnosis, is provided to the referring practitioner which must: a) comprehensively evaluate biological, psychological and social issues; b) address diagnostic psychiatric issues; c) make management recommendations addressing biological, psychological and social issues; and d) be provided to the referring practitioner within two weeks of completing the assessment of the patient. - The diagnosis and management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - The diagnosis and management plan is communicated in writing to the referring practitioner Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item	$518.80

00293	Consultant psychiatrist, review of referred patient assessment and management professional attendance by a consultant physician in the practice of his or her speciality of psychiatry to review a management plan previously prepared by that consultant psychiatrist for a patient and claimed under item 291, where the review is initiated by the referring medical practitioner practising in general practice or participating nurse practitioner.an attendance of more than 30 minutes but not more than 45 minutes duration at consulting rooms where that attendance follows item 291 and during which:- an outcome tool is used where clinically appropriate- a mental state examination is conducted- a psychiatric diagnosis is made- a management plan provided under item 291 is reviewed and revised- the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)- the reviewed management plan is communicated in writing to the referring medical practitioner or participating nurse practitioner being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 291, and no payment has been made under item 359, payable no more than once in any 12 month period.	$324.20
00296	Consultant psychiatrist, initial consultation on a new patient, consulting rooms professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of psychiatry where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or- is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. not being an attendance on a patient in respect of whom payment has been made under this item, items 297 or 299, or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period	$358.10
00297	Consultant psychiatrist, initial consultation on a new patient, hospital. Professional attendance of more than 45 minutes at hospital by a consultant physician in the practice of his or her speciality of psychiatry where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or- is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 299 or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period	$358.10
00299	Consultant psychiatrist, initial consultation on a new patient, home visits Professional attendance of more than 45 minutes at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her speciality of psychiatry where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 297, or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period	$424.50
00300	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a referring practitioner an attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year.	$76.90
00302	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year.	$155.20
00304	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50	$229.50

	attendances in a calendar year	
00306	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year	$331.50
00308	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year	$373.10
00310	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year.	$89.30
00312	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year .	$138.50
00314	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year .	$188.80
00316	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year .	$241.80
00318	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year .	$247.00
00319	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner - an attendance of more than 45 minutes duration at consulting rooms, where the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale - where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply do not exceed 160 attendances in a calendar year .	$280.20
00320	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a referring practitioner an attendance of not more than 15 minutes duration at hospital	$76.90
00322	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital	$155.20

00324	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital	$229.50
00326	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital	$331.50
00328	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration at hospital	$384.60
00330	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a referring practitioner an attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital	$104.40
00332	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital	$169.70
00334	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital	$232.10
00336	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital	$331.50
00338	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital	$450.10
00342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner each patient	$78.70
00344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a medical practitioner each patient	$108.20
00346	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a medical practitioner each patient	$154.50
00348	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient	$207.80

00350	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient of not less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient	$301.40
00352	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period	$145.30
00353	A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of psychiatry (not being an attendance to which items 291 to 319 apply), where: - the patient is referred to him or her by a referring practitioner for assessment, diagnosis and/or treatment and is located in a regional, rural or remote area (rrma3-7), -that consultation and any other consultation to which items 353 to 361 apply, have not exceeded 12 consultations in a calendar year, - any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year.a telepsychiatry consultation of not more than 15 minutes duration.	$80.30
00355	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration.	$160.30
00356	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration.	$235.30
00357	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration	$324.70
00358	A telepsychiatry consultation of more than 75 minutes duration	$395.50
00359	A telepsychiatry consultation of more than 30 minutes but not more than 45 minutes duration by a consultant physician in the practice of his or her specialty of psychiatry where: the patient is located in a regional, rural or remote area (rrma 3-7)in the preceding 12 months, payment has been made under item 291an outcome tool is used where clinically appropriate a mental state examination is conducted a psychiatric diagnosis is made a management plan provided under item 291 is reviewed and revised the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)the reviewed management plan is communicated in writing to the referring practitioner not being an attendance on a patient in respect of whom payment has been made under this item or item 293 in the preceding 12 month period.	$448.10
00361	A telepsychiatry consultation of more than 45 minutes by a consultant physician in the practice of his or her specialty of psychiatry where: the patient is a new patient for this consultant psychiatrist, or a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months the patient is located in a regional, rural or remote area (rrma3-7)not being an attendance on a patient in respect of whom payment has been made under this item, items 296 to 299, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period.	$342.90
00364	Consultant psychiatrist, referred consultation for assessment, diagnosis and treatment following professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where: - the patient is referred to him or her by a referring practitioner, - that attendance occurs following a telepsychiatry consultation (items 353 to 361), - that attendance and any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. these items may only be used after telepsychiatry consultation(s) have been conducted in accordance with items 353 to 361.a face-to-face attendance of not more than 15 minutes duration.	$68.60
00366	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration	$139.50

00367	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration.	$204.40
00369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration	$310.10
00370	A face-to-face attendance of more than 75 minutes duration.	$337.40

GROUP A13 – PUBLIC HEALTH PHYSICIAN ATTENDANCE TO WHICH NO OTHER ITEM APPLIES

00410	Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.	$30.80
00411	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 and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation.	$67.30
00412	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 and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation	$127.80
00413	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 and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation.	$188.00
00414	Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. Derived Fee: The fee for item 410 ($30.80), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $2.40 per patient	DF
00415	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation Derived Fee: The fee for item 411 ($67.30), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $2.40 per patient	DF
00416	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation. Derived Fee: The fee for item 412 ($127.80), plus $41.60 divided by the number of	DF

patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $2.40 per patient

00417 Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation. DF

Derived Fee: The fee for item 413 ($188.00), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $2.40 per patient

GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

Consultations

00501 Medical practitioner (emergency physician) attendances emergency department level 1 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making. $62.00

00503 Medical practitioner (emergency physician) attendances emergency department level 2 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity. $106.40

00507 Medical practitioner (emergency physician) attendances emergency department level 3 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity. $176.00

00511 Medical practitioner (emergency physician) attendances emergency department level 4 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity. $250.00

00515 Medical practitioner (emergency physician) attendances emergency department level 5 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a $314.70

	patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity.	
	Prolonged professional attendances	
00519	Medical practitioner (emergency physician) attendances emergency department professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed - for a period of not less than 30 minutes but less than 1 hour of total physician time spent with each patient	$237.30
00520	For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient.	$368.20
00530	For a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient	$583.50
00532	For a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient.	$817.00
00534	For a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient.	$1,050.70
00536	For a period of 5 hours or more of total physician time spent with each patient.	$992.30

GROUP A11 - URGENT ATTENDANCE AFTER HOURS

	After hours	
00597	Professional attendance by a general practitioner on not more than 1 patient on 1 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, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's condition requires urgent medical treatment; and(b) if the attendance is performed at consulting rooms - it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$183.00
00598	Professional attendance by a medical practitioner (other than a general practitioner) or a general practitioner to whom rule 5a applies, on not more than 1 patient on 1 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, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's condition requires urgent medical treatment; and(b) if the attendance is at consulting rooms - it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$183.00
	Unsociable hours	
00599	Professional attendance by a general practitioner on not more than 1 patient on 1 occasion - each attendance in unsociable hours if:(a) the attendance is requested by the patient or a	$193.70

	responsible person in, or not more than 2 hours before the start of, the same unbroken after- hours period, and the patient's condition requires urgent medical treatment; and(b) if the attendance is at consulting rooms - it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	
00600	Professional attendance by a medical practitioner (other than a general practitioner) or a general practitioner to whom rule 5a applies, on not more than 1 patient on 1 occasion - each attendance in unsociable hours if:(a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after- hours period, and the patient's condition requires urgent medical treatment; and(b) if the attendance is at consulting rooms - it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$203.80

GROUP A14 – HEALTH ASSESSMENTS

00701	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or a consultant physician) 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	$67.20
00703	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or a consultant physician) 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	$155.00
00705	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or a consultant physician) 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	$213.80
00707	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) 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	$302.00
00715	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) 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	$238.40

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. This Chronic Disease Management (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. The GPMP must be in writing and contain suggestions to facilitate a return to work. A copy of the GPMP must be given to the patient. A fee will not be paid within 12 months of a previous claim for item 721, or within 3 months of a claim for item 732 (for a review of a GPMP), except where there are exceptional circumstances that require the preparation of a new GPMP.	$162.40

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. This Chronic Disease Management (CDM) service is for a patient who: (a) has at least one medical condition that has been (or is likely to be) present for at least six months; 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. The medical practitioner shall document the TCA and provide a copy to the collaborating health or care providers and to the patient. A fee will not be paid within 12 months of a previous claim for item 723, or within 3 months of a claim for item 732 (for review of TCAs), except where there are exceptional circumstances that require the coordination of new TCAs.	$128.40
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). This Chronic Disease Management 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 provides, 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 3 month period, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient.	$81.30

GROUP A17 - DOMICILIARY MEDICATION MANAGEMENT REVIEW

00900	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a Domiciliary Medication Management Review (dmmr) for patients living in the community setting, where the medical practitioner: - assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy or an accredited pharmacist for a dmmr, and provides relevant clinical information required for the review, with the patient's consent; and - discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and - develops a written medication management plan following discussion with the patient. Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new dmmr.	$239.00
00903	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a collaborative Residential Medication Management Review (rmmr) for a permanent resident of a residential aged care facility, where the medical practitioner: discusses and seeks consent for an rmmr from the new or existing resident; collaborates with the reviewing pharmacist regarding the pharmacy component of the review; provides input from the resident's Comprehensive Medical Assessment (cma), or if a cma has not been undertaken, provides relevant clinical information for the resident's rmmr; discusses findings of the pharmacist review and proposed medication management strategies with the reviewing pharmacist (unless exceptions apply); - develops and/or revises a written medication plan for the resident; and consults with the resident to discuss the medication management plan and its implementation. Benefits under this item are payable for one rmmr service for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis, with a maximum of one rmmr for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen requiring a new rmmr.	$163.60

GROUP A30 - MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES

02100	Level A - Telehealth attendance at consulting rooms professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; (B) or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies	$32.40
02122	Level A - Telehealth attendance other than at consulting rooms professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2100 ($32.40) plus $38.20 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $2.90 per patient.	DF
02126	Level B - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who:(a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and(c) either: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (a) an Aboriginal medical service; or (b) an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the Act applies	$70.70
02137	Level B - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2126 ($70.70) plus $38.20 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $2.90 per patient.	DF
02143	Level C - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies	$137.00
02147	Level C - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a	DF

medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient.

Derived Fee: The fee for item 2143 ($137.00) plus $38.20 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $2.90 per patient.

02195 Level D - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies $201.60

02199 Level D - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance - at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion - each patient. DF

Derived Fee: The fee for item 2195 ($201.60) plus $38.20 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $2.90 per patient.

GROUP A30 – MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES

02125 Level A - Telehealth attendance at a residential aged care facility a professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is:a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self- contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit) and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. DF

Derived Fee: The fee for item 2100 ($32.40) plus $68.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $4.90 per patient.

02138 Level B - Telehealth attendance at residential aged care facility 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. DF

Derived Fee: The fee for item 2126 ($70.70) plus $68.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $4.90 per patient.

02179	Level C - A professional attendance by a medical practitioner (not being a service to which any other items applies) lasting at least 20 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is:a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit) or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self- contained unit) and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. Derived Fee: The fee for item 2143 ($137.00) plus $68.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $4.90 per patient.	DF
02220	Level D - Telehealth attendance at residential aged care facility a professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self- contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit);and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. Derived Fee: The fee for item 2195 ($201.60) plus $68.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $4.90 per patient.	DF

GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS

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

02497	Level A - Professional attendance involving taking a short patient history and if required, limited examination and management and at which a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. This item cannot be claimed in conjunction with items 10994, 10995, 10998 or 10999 surgery consultation (Professional attendance at consulting rooms)	$26.10
02501	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	$57.80
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 1 or more health- related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years Derived Fee: The fee for item 2501 ($57.80), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $2.40 per patient	DF
02504	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary	$108.60

	investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	
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 1 or more health- related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years Derived Fee: The fee for item 2504 ($108.60), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $2.40 per patient	DF
02507	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	$159.90
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 1 or more health- related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years Derived Fee: The fee for item 2507 ($159.90), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $2.40 per patient	DF
	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 1 or more health- related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$57.20
02518	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus Derived Fee: The fee for item 2517 ($57.20), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $2.40 per patient	DF
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	$108.60

	patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	
02522	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus Derived Fee: The fee for item 2521 ($108.60), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus $2.40 per patient	DF
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 1 or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$159.90
02526	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus Derived Fee: The fee for item 2525 ($159.90), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus $2.40 per patient	DF
	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 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care	$57.20
02547	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care Derived Fee: The fee for item 2546 ($57.20), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $2.40 per patient	DF
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	$108.60

	investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care	
02553	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care Derived Fee: The fee for item 2552 ($108.60), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $2.40 per patient	DF
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 1 or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care	$159.90
02559	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care Derived Fee: The fee or item 2558 ($159.90), plus $41.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $2.40 per patient	DF

GROUP A20 - GP MENTAL HEALTH CARE

GP mental health care plans

02700	Preparation by a medical practitioner who has not undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a gp mental health treatment plan for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 20 minutes. a rebate will not be paid within twelve months of a previous claim for the same item or item 2701, 2715 or 2717 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new gp mental health treatment plan.	$111.60
02701	Preparation by a medical practitioner who has not undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a gp mental health treatment plan for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 40 minutes. a rebate will not be paid within twelve months of a previous claim for the same item or item 2700, 2715 or 2717 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new gp mental health treatment plan	$164.20
02712	attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to review a gp mental health treatment plan prepared by that medical practitioner (or an associated medical practitioner) to which item 2700, 2701, 2715, 2717 or former items 2702 and 2710 applies or to review a psychiatrist assessment and management plan to which item 291 applies (not being a service associated with a service to which items 2713 or 735 to 758 apply).a rebate will not be paid within three	$179.10

	months of a previous claim for item 2712 or within four weeks following a claim for item 2700, 2701, 2715 or 2717, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new review of a gp mental health treatment plan.	
02713	Professional attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) involving taking relevant history, identifying presenting problem(s), providing treatment, advice and/or referral for other services or treatments and documenting the outcomes of the consultation, on a patient in relation to a mental disorder and lasting at least 20 minutes (not being a service associated with a service to which items 2700, 2701, 2715, 2717 or 2712 apply).surgery consultation (Professional attendance at consulting rooms)	$123.90
02715	Preparation by a medical practitioner who has undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a gp mental health treatment plan for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 20 minutes. a rebate will not be paid within twelve months of a previous claim for the same item or item 2700, 2701 or 2717 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new gp mental health treatment plan	$141.70
02717	Preparation by a medical practitioner who has undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a gp mental health treatment plan for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 40 minutes. a rebate will not be paid within twelve months of a previous claim for the same item or item 2700, 2701 or 2715 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new gp mental health treatment plan.	$208.60
	Focussed psychological strategies	
02721	Medical practitioner attendance (including a general practitioner, but not including a specialist or consultant physician) associated with provision of focussed psychological strategies Note: These services may only be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialled medical practitioner and are time limited; being deliverable, in up to ten planned sessions per calendar year. in exceptional circumstances, following review by the practitioner managing the patient either under the gp mental health treatment plan or under the psychiatric assessment and management plan, up to a further 6 services may be approved from 1 March 2012 to 31 December 2012 to an individual patient. Medical practitioners must be notified to Medicare Australia by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills. a session should last for a minimum of 30 minutes. fps attendance Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental disorders by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes to less than 40 minutes. surgery consultation (Professional attendance at consulting rooms)	$125.80
02723	Out-of-surgery consultation (professional attendance at a place other than consulting rooms). Derived fee: The fee for item 02721 ($125.80), plus $41.60 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for item 02721 plus $2.40 per patient.	DF

02725	Fps extended attendance professional attendance for the purpose of providing focussed psychological strategies for assessed mental health disorders, by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes. surgery consultation (professional attendance at consulting rooms).	$168.90
02727	Out-of-surgery consultation (professional attendance at a place other than consulting rooms) Derived fee: The fee for item 02725 ($168.90), plus $41.60 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for item 02725 plus $2.40 per patient.	DF

GROUP A24 - PAIN AND PALLIATIVE MEDICINE

Pain medicine attendances

02799	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	$169.80
02801	Medical practitioner (pain medicine specialist) attendance - surgery or hospital Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a referring practitioner - initial attendance in a single course of treatment	$253.00
02806	- each attendance (other than a service to which item 2814 applies) subsequent to the first in a single course of treatment	$119.40
02814	- each minor attendance subsequent to the first in a single course of treatment	$61.50
02820	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if:(a) the attendance is by video conference; (b) and the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; and (c) the patient is not an admitted patient; and(d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item.	DF
02824	Medical practitioner (pain medicine specialist) attendance - home visit Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner - initial attendance in a single course of treatment	$259.30
02832	- each attendance (other than a service to which item 2840 applies) subsequent to the first in a single course of treatment	$148.90
02840	- each minor attendance subsequent to the first in a single course of treatment	$112.40

Pain medicine case conferences

02946	Case conferences - pain medicine specialist Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference	$220.10

	team, to organise and coordinate a community case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	
02949	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$330.30
02954	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$440.10
02958	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$114.60
02972	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$240.00
02974	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$250.70
02978	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$239.40
02984	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$330.30
02988	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$440.10
02992	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$149.40
02996	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$240.00
03000	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$327.40

Palliative medicine attendances

03003	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	$169.80
03005	Medical practitioner (palliative medicine specialist) attendance - surgery or hospital Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a referring practitioner - initial attendance in a single course of treatment	$232.10
03010	- each attendance (other than a service to which item 3014 applies) subsequent to the first in a single course of treatment	$119.40
03014	- each minor attendance subsequent to the first in a single course of treatment	$61.50
03015	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if:(a) the attendance is by video conference; and(b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and(d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (a) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item.	DF
03018	Medical practitioner (palliative medicine specialist) attendance - home visit Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a referring practitioner - initial attendance in a single course of treatment	$259.30
03023	- each attendance (other than a service to which item 3028 applies) subsequent to the first in a single course of treatment	$148.90
03028	- each minor attendance subsequent to the first in a single course of treatment	$112.40

Palliative medicine case conferences

03032	Case conferences - palliative medicine specialist Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$220.10
03040	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$330.30
03044	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$440.10

03051	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$114.60
03055	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$207.50
03062	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$327.40
03069	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$239.40
03074	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$359.30
03078	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines	$478.80
03083	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$149.40
03088	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$240.00
03093	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines	$327.40

GROUP A27 - PREGNANCY SUPPORT COUNSELLING

04001	Medical practitioner attendance (including a general practitioner, but not including a specialist or consultant physician) associated with provision of non-directive pregnancy support counselling services Professional attendance for the purpose of providing non-directive pregnancy support counselling to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 20 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate. This service may not be provided by a medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of 3 non-directive pregnancy support counselling	$118.20

services per patient, per pregnancy from any of the following items - 4001, 81000, 81005 and 81010 (see Explanatory note m.8). surgery consultation (professional attendance at consulting rooms)

GROUP A22 – GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

05000	Level A - professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management surgery consultation professional attendance at consulting rooms. the attendance must be initiated either on a public holiday, on a sunday, before 8am or after 1pm on a saturday, or before 8am or after 8pm on any other day.	$39.00
05003	Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this table applies) that requires a short patient history and, if necessary, limited examination and management - an attendance on 1 or more patients on 1 occasion - each patient Derived fee: The fee for Item 5000 ($39.00), plus $41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $2.30 per patient.	DF
05010	Consultation at a residential aged care facility professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self- contained unit) on 1 occasion) each patient. the attendance must be initiated either on a public holiday, on a sunday, before 8am or after 12noon on a saturday, or before 8am or after pm on any other day. Derived fee: The fee for Item 5000 ($39.00), plus $74.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $2.30 per patient.	DF
05020	Professional attendance by a general practitioner at consulting rooms (not being a service to which any other item in this table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - each attendance	$78.50
05023	Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - an attendance on 1 or more patients on 1 occasion - each patient Derived fee: The fee for Item 5020 ($78.50), plus $41.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.30 per patient.	DF
05028	Professional attendance by a general practitioner (not being a service to which any other item in this table applies), at a residential aged care facility to residents of the facility, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation	DF

	- an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient Derived fee: The fee for Item 5020 ($78.50), plus $74.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.30 per patient.	
05040	Professional attendance by a general practitioner at consulting rooms (not being a service to which any other item in this table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - each attendance	$111.00
05043	Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients on 1 occasion - each patient Derived fee: The fee for Item 5040 ($111.00), plus $41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $2.30 per patient.	DF
05049	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient Derived fee: The fee for Item 5040 ($111.00), plus $74.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $2.30 per patient.	DF
05060	Professional attendance by a general practitioner at consulting rooms (not being a service to which any other item in this table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - each attendance	$172.40
05063	Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients on 1 occasion - each patient Derived fee: The fee for Item 5060 ($172.40), plus $41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $2.30 per patient.	DF
05067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:(a)	DF

	taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient Derived fee: The fee for Item 5060 ($172.40), plus $74.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $2.30 per patient.	

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	$145.80
06007	Professional attendance at consulting rooms or hospital by a specialist practising in the specialty of neurosurgery, where the patient was referred to him or her by a medical practitioner. - Initial attendance in a single course of treatment.	$235.00
06009	Each minor attendance subsequent to the first in a single course of treatment. - An attendance of not more than 15 minutes duration.	$78.00
06011	Each attendance subsequent to the first in a single course of treatment being an attendance involving a detailed and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems. An attendance of more than 15 minutes duration but not more than 30 minutes duration.	$154.30
06013	Each attendance subsequent to the first in a single course of treatment being an attendance involving an extensive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems. An attendance of more than 30 minutes duration but not more than 45 minutes duration.	$212.80
06015	Each attendance subsequent to the first in a single course of treatment being an attendance involving an exhaustive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems - An attendance of more than 45 minutes duration.	$251.20
06016	Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) item 6007, 6009, 6011, 6013 or 6015 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) outside an inner metropolitan area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; (b) or an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item.	DF

GROUP A9 - CONTACT LENSES - ATTENDANCES

10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye	$191.50
10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in	$191.50

	any period of 36 months - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye	
10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients with astigmatism of 3.0 dioptres or greater in 1 eye	$191.50
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	$222.20
10805	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	$191.50
10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system	$191.50
10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity - whether congenital, traumatic or surgical in origin	$191.50
10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients who, by reason of physical deformity, are unable to wear spectacles	$191.50
10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription - 1 service in any period of 36 months - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, where the condition is specified on the patient's account	$191.50
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens to which Items 10801 to 10809 apply	$191.50

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

Neurology

11000	Electroencephalography, not being a service:(a) associated with a service to which item 11003,11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.)	$224.20
11003	Electroencephalography, prolonged recording of at least3 hours duration, not being a service: (a) associated with a service to which item 11000,11004, 11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	$482.80

11004	Electroencephalography, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000,11003, 11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	$538.50
11005	Electroencephalography, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hoursduration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000,11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	$515.50
11006	Electroencephalography, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices	$249.90
11009	Electrocorticography	$333.90
11012	Neuromuscular electrodiagnosis - conduction studieson 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)	$177.30
11015	Neuromuscular electrodiagnosis - conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies)	$252.70
11018	Neuromuscular electrodiagnosis - conduction studies on 4 or more nerves with or without electromyography or recordings from single fibres of nerves and muscles or both of these examinations (not being a service associated with a service to which item 11012 or 11015applies)	$369.40
11021	Neuromuscular electrodiagnosis - repetitive stimulation for study of neuromuscular conduction or electromyography with quantitative computerised analysis or both of these examinations	$250.00
11024	Central nervous system evoked responses, investigation of, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or involving multifocal multichannel objective perimetry - 1 or 2 studies	$167.50
11027	Central nervous system evoked responses, investigation of, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or involving multifocal multichannel objective perimetry - 3 or more studies	$247.30

Opthalmology

11200	Provocative test or tests for glaucoma, including water drinking	$59.40
11204	Electroretinography of 1 or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	$170.30
11205	Electrooculography of 1 or both eyes performed according to current professional guidelines or standards	$170.30
11210	Pattern electroretinography of 1 or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	$170.30
11211	Dark adaptometry of 1 or both eyes with a quantitative estimation of threshold in log lumens at 45 minutes of dark adaptations	$170.30
11215	Retinal photography, multiple exposures, of 1 eye with intravenous dye injection	$224.00
11218	Retinal photography, multiple exposures of both eyes with intravenous dye injection	$276.90
11221	Full quantitative computerised perimetry (automated absolute static threshold), not being 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	$155.70

	ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 11224 applies) in any 12 month period	
11222	Full quantitative computerised perimetry (automated absolute static threshold), not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, if it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11221 applies due to presence of 1 of the following conditions: (a) established glaucoma (when surgery may be required within a 6 month period) if there has been definite progression of damage over a 12 month period; (b) established neurological disease which may be progressive and if a visual field is necessary for the management of the patient; (c) monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, if there may also be other disease such as glaucoma or neurological disease; each additional examination	$149.50
11224	Full quantitative computerised perimetry (automated absolute static threshold), not being 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 2 examinations (including examinations to which item 11221 applies) in any 12 month period	$86.80
11225	Full quantitative computerised perimetry (automated absolute static threshold), not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, if it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of 1 of the following conditions: (a) established glaucoma (when surgery may be required within a 6 month period) if there has been definite progression of damage over a 12 month period; (b) established neurological disease which may be progressive and if a visual field is necessary for the management of the patient; (c) monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, if there may also be other disease such as glaucoma or neurological disease; each additional examination	$82.40
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	$225.10
11237	Ocular contents, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, 1 eye, not being a service associated with a service to which an item in group I1 of the Diagnostic Imaging Services Table applies	$146.40
11240	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of 1 eye prior to lens surgery on that eye, not being a service associated with a service to which an item in group I1 of the Diagnostic Imaging Services Table applies	$146.40
11241	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which an item in group I1 of the Diagnostic Imaging Services Table applies	$172.80
11242	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which an item in group I1 of the Diagnostic Imaging Services Table applies	$137.80
11243	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye if: (a) surgery for the first eye has resulted in more	$126.10

	than 1 dioptre of error; or (b) more than 3 years have elapsed since the surgery for the first eye; not being a service associated with a service to which an item in group I1 of the Diagnostic Imaging Services Table applies	
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.	$118.20

Otolaryngology

11300	Brain stem evoked response audiometry (Anaes.)	$290.90
11303	Electrocochleography, extratympanic method, 1 or both ears	$290.90
11304	Electrocochleography, transtympanic membrane insertion technique, 1 or both ears	$474.00
11306	Non-determinate audiometry	$32.70
11309	Audiogram, air conduction	$38.30
11312	Audiogram, air and bone conduction or air conduction and speech discrimination	$55.30
11315	Audiogram, air and bone conduction and speech	$72.40
11318	Audiogram, air and bone conduction and speech, with other cochlear tests	$101.20
11321	Glycerol induced cochlear function changes assessed bya minimum of 4 air conduction and speech discrimination tests (Klockoff's test)	$170.80
11324	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, if the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	$55.30
11327	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, if the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	$34.80
11330	Impedance audiogram if the patient is not referred by a medical practitioner - 1 examination in any 4 week period	$13.30
11332	Oto-acoustic emission audiometry for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to 1 or more of the following factors: (a) admission to a neonatal intensive care unit; (b) family history of hearing impairment; (c) intra-uterine or perinatal infection (either suspected or confirmed); (d) birthweight less than 1.5 kg; (e) craniofacial deformity; (f) birth asphyxia; (g) chromosomal abnormality, including Down's Syndrome; (h) exchange transfusion; if: (i) the patient is referred by another medical practitioner; and (j) middle ear pathology has been excluded by specialist opinion	$92.20
11333	Caloric test of labyrinth or labyrinths	$72.00
11336	Simultaneous bithermal caloric test of labyrinths	$80.80
11339	Electronystagmography	$72.40

Respiratory

11500	Bronchospirometry, including gas analysis	$264.30
11503	Measurement of the:(a) mechanical or gas exchange function of the respiratory system; or (b) respiratory muscle function; or (c) ventilatory control mechanisms.various measurement parameters may be used including: (a) pressures; (b) volumes; (c) flow; (d) gas concentrations in inspired or expired air; (e) alveolar gas or blood; (f) electrical activity of muscles. the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital. each occasion at which 1 or more such tests are performed, not being a service associated with a service to which item 22018	$220.30

	applies.	
11506	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed	$30.80
11509	Measurement of respiratory function involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed	$60.80
11512	Continuous measurement of the relationship between flow and volume during expiration or inspiration involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed	$90.60
	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)	$96.50
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 valsava manoeuvres, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 or 32501 applies - hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of two examinations in a 12 month period, not to be used in conjunction with sclerotherapy.	$85.30
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 or 32501 applies.	$89.00
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease, hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 or 32501 applies.	$86.60
11610	Measurement of ankle - brachial indices and arterial waveform analysis, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using doppler or plethysmographic techniques, the calculation of ankle (or toe) brachialsystolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterialdisease - examination, hard copy trace and report	$85.30
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, hardcopy trace and report	$85.30
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	$133.80

	workload is quantifiably documented - examination and report	
11614	Transcranial doppler, examination of the intracranial arterial circulation using CW Doppler or pulsed doppler with hard copy recording of waveforms, examination and report, not being a service associated with a service to which item 55280 of the Diagnostic Imaging Services Table applies	$89.00
11615	Measurement of digital temperature, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing	$125.20
11627	Pulmonary artery pressure monitoring during open heart surgery, in a person under 12 years of age	$360.10
	Cardiovascular	
11700	Twelve-lead electrocardiography, tracing and report	$50.40
11701	Twelve-lead electrocardiography, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion	$25.00
11702	Twelve-lead electrocardiography, tracing only	$25.00
11708	Continuous ECG recording of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician. Not being a service to which item 11709 applies. The changing of a tape or batteries does not constitute a separate service. where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service.	$202.20
11709	Continuous ECG recording (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service.	$271.70
11710	Ambulatory ECG monitoring, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period	$89.90
11711	Ambulatory ECG monitoring for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period	$52.00
11712	Multi channel ECG monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator	$252.70
11713	Signal averaged ECG recording involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician	$128.30
11715	Blood dye - dilution indicator test	$191.60

11718	Implanted pacemaker testing involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700 or 11721 applies	$57.60
11721	Implanted pacemaker testing of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which item 11700 or 11718 applies	$114.00
11722	Implanted ECG loop recording for the investigation of recurrent unexplained syncope if: (a) a diagnosis has not been achieved through all other available cardiac investigations; and (b) a neurogenic cause is not suspected; and (c) the patient to whom the service is provided does not have a structural heart defect associated with a high risk of sudden cardiac death; including reprogramming when required, retrieval of stored data, analysis, interpretation and report, not beinga service to which item 38285 applies	$57.70
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	$306.60
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 11700, 11718 or 11721 applies	$151.70
	Gastroenterology and colorectal	
11800	Oesophageal motility test, manometric	$316.10
11810	Clinical assessment of gastro- oesophageal reflux disease involving 24-hour pH monitoring, including analysis, interpretation and report and including any associated consultation	$272.40
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopydevice 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 orconsultant physician with endoscopic training that is recognised by the conjoint committee for there cognition of training in gastrointestinal endoscopy; and (b) the patient to whom the service is provided: (i) is aged 10 years or over; and (ii) has recurrent or persistent bleeding; and (iii) is anaemic or has active bleeding; and (c) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding;and (d) the service is performed within 6 months after the upper gastrointestinal endoscopy and colonoscopy; (e) the service is not associated with double balloon enteroscopy (f) the service has not been provided to the same patient:(i) more than once in an episode of bleeding, being bleeding occurring within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy (any bleeding after that time is considered to be a new episode); or (ii) on more than 2 occasions in any 12 month period	$2,341.00
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. the procedure includes the administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered (not being a service associated with double balloon enteroscopy).medicare benefits are only payable for this item if:the service has been 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 the patient to whom the service is provided has been conclusively diagnosed with peutz-jeghers syndrome (pjs) this item is available once in any two year period.	$3,227.10

11830	Diagnosis of abnormalities of the pelvic floor involving anal manometry or measurement of anorectal sensationor measurement of the rectosphincteric reflex	$224.50
11833	Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	$383.70
	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	$45.40
11903	Cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11912, 11915, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies	$205.50
11906	Urethral pressure profilometry, not being a service associated with a service to which any of items 11012 to 11027, 11909, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies	$178.90
11909	Urethral pressure profilometry with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies	$261.30
11912	Cystometrography with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012 to 11027, 11903, 11915, 11919, 11921 and 36800 or an item in group I3of the Diagnostic Imaging Services Table applies (Anaes.)	$267.10
11915	Cystometrography with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 11012 to 11027, 11903, 11909, 11912, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies (Anaes.)	$267.10
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 any of items 11012 to 11027, 11900 to 11915, 11919, 11921 and 36800 applies (Anaes.)	$690.80
11919	Cystometrography in conjunction with contrast micturating cystourethrography, with measurement ofany 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11900 to 11917, 11921 and 36800 applies (Anaes.)	$690.80
11921	Bladder washout test for localisation of urinary infection - not including bacterial counts for organisms in specimens	$134.80
	Allergy testing	
12000	Skin sensitivity testing for allergens, using 1 to 20 allergens, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies	$68.20
12003	Skin sensitivity testing for allergens, using more than 20 allergens, not being a service associated with a service to which item 12012, 12015, 12018 or 12021applies	$102.50
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery	$36.80
12015	Epicutaneous patch testing in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery	$110.70
12018	Epicutaneous patch testing in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery and additional allergens to a total of up to and including 50 allergens	$145.50

12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens	$217.20

Other diagnostic procedures and investigations

12200	Collection of specimen of sweat by iontophoresis	$67.50
12201	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well- differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness- applicable once only in a 12 month period	$2,742.20
12203	Overnight investigation for sleep apnoea for a period of at least 8 hours duration, for a patient aged 18 years or more, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; and (b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. For any particular patient - applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	$845.50
12207	Overnight investigation for sleep apnoea for a period of at least 8 hours duration, for a patient aged 18 years or more, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; and (b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure) in sleep, in a patient with severe cardio-respiratory failure, and if previous studies have demonstrated failure of continuous positive airway pressure or oxygen - each additional investigation	$845.50
12210	Overnight paediatric investigation for a period of at least 8 hours duration for a patient aged 12 years or less, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG (with a minimum of 4 EEG leads	$1,105.00

	or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; and (e) polygraphic records are 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 manualcorrection of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. For each particular patient - applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month	
12213	Overnight paediatric investigation for a period of at least 8 hours duration for a patient aged between 12 and 18 years, if: (a) recordings of EEG (with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment ofclinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. For each particular patient - applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	$995.50
12215	Overnight paediatric investigation for a period of at least 8 hours duration for a patient aged 12 years or less, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG (with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; and (e) polygraphic records are 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 stored for interpretation and preparation of 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; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for the adjustment, or testing of the effectiveness, or both, of Continuous Positive Airway Pressure (CPAP) or of the bilevel pressure support or ventilation (or both), or if supplemental oxygen is required because of recurring hypoxia - each additional investigation	$1,105.00

12217	Overnight paediatric investigation for a period of at least 8 hours duration for a patient aged between 12 and 18 years, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG (with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment ofclinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for the adjustment, or testing of the effectiveness, or both, of Continuous Positive Airway Pressure (CPAP) or of the bilevel pressure support or ventilation (or both), or if there is recurring hypoxia and supplemental oxygen is required - each additional investigation	$995.50
12250	Overnight investigation for sleep apnoea for a period of at least 8 hours duration for a patient aged 18 years or more, if all of the following requirements are met:(a) the patient has, before the overnight investigation, been referred to a qualified adult sleep medicine practitioner by a medical practitioner whose clinical opinion is that there is a high probability that the patient has obstructive sleep apnoea; and(b) the investigation takes place after the qualified adult sleep medicine practitioner has: (i) confirmed the necessity for the investigation; and (ii) communicated this confirmation to the referring medical practitioner; and(c) during a period of sleep, the investigation involves recording a minimum of seven physiological parameters which must include: (i) continuous electro-encephalogram (eeg); and (ii) continuous electro-cardiogram (ecg; and (iii) airflow; and (iv) thoraco-abdominal movement; and (v) oxygen saturation; and (vi) 2 or more of the following: (a) electro-oculogram (eog); (b) chin electro-myogram (emg); (c) body position; and(d) in the report on of the investigation, the qualified adult sleep medicine practitioner uses the data specified in paragraph (c) to: (i) analyse sleep stage, arousals and respiratory events; and (ii) assess clinically significant alteration in heart rate; and(e) the qualified adult sleep medicine practitioner: (i) before the investigation takes place, establishes quality assurance procedures for data acquisition; and (ii) personally analyses the data and writes the report on the results of the investigation.payable only once in a 12 month period.	$530.60
12306	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for: the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - 1 service only in a period of 24 months - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination)	$170.80
12309	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for: the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - 1 service only in a period of 24 months - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination)	$170.80

12312	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: prolonged glucocorticoid therapy; conditions associated with excess glucocorticoid secretion; male hypogonadism; or female hypogonadism lasting more than 6 months before the age of 45. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination)	$170.80
12315	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner),using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: primary hyperparathyroidism; chronic liver disease; chronic renal disease; proven malabsorptive disorders; rheumatoid arthritis; or conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination)	$170.80
12318	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: prolonged glucocorticoid therapy; conditions associated with excess glucocorticoid secretion; male hypogonadism; female hypogonadism lasting more than 6 months before the age of 45; primary hyperparathyroidism; chronic liver disease; chronic renal disease; proven malabsorptive disorders; rheumatoid arthritis; or conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination)	$162.10
12321	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the measurement of bone density 12 months following a significant change in therapy for: established low bone mineral density; or the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. Measurement of 2 or more sites - 1 service only in a period of 12 consecutive months -including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination).	$170.80
12323	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry or quantitative computerised tomography, for the measurement of bone mineral density, for a person aged 70 years or over. Measurement of 2 or more sites - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination).	$161.30

GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)

12500	Blood volume estimation	$319.50
12503	Erythrocyte radioactive uptake survival time test or iron kinetic test	$589.40
12506	Gastrointestinal blood loss estimation involving examination of stool specimens	$426.20
12509	Gastrointestinal protein loss	$319.50
12512	Radioactive B12 absorption test - 1 isotope	$177.80

12515	Radioactive B12 absorption test - 2 isotopes	$333.90
12518	Thyroid uptake (using probe)	$166.30
12521	Perchlorate discharge study	$200.40
12524	Renal function test (without imaging procedure)	$250.50
12527	Renal function test (with imaging and at least 2 blood samples)	$134.30
12530	Whole body count - not being a service associated with a service to which another item applies	$200.40
12533	Carbon-labelled urea breath test using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled 13CO2 or 14CO2 , for either: (a) the confirmation of helicobactor pylori colonisation; or (b) the monitoring of the success of eradication of helicobactor pylori in patients with peptic ulcer disease. not being a service to which 66900 applies	$133.80

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.	$401.10
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	$410.00
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)	$212.50
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)	$258.50

Dialysis

13100	Supervision in hospital by a medical specialist of - haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day	$229.60
13103	Supervision in hospital by a medical specialist of - haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day	$128.10
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	$234.20

13106	Declotting of an arteriovenous shunt	$173.40
13109	Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis insertion and fixation of (Anaes.)	$416.60
13110	Tenckhoff peritoneal dialysis catheter, removal of (including catheter cuffs) (Anaes.)	$359.70
13112	Peritoneal dialysis, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)	$255.00

Assisted reproductive services

13200	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - initial cycle in a single calendar year	$4,705.80
13201	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle subsequent to the first in a single calendar year	$4,398.90
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	$705.90
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	$845.10
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	$1,251.10
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 purposes of assisted reproductive technologies - only if rendered in conjunction with a service to which item 13200, 13201 or 13206 applies (Anaes.)	$573.50

13215	Transfer of embryos or both ova and sperm to the female reproductive system, excluding artificial insemination - only if rendered in conjunction with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in 1 treatment cycle (Anaes.)	$204.40
13218	Preparation of frozen or donated embryos or donated oocytes for transfer to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.)	$1,729.70
13221	Preparation of semen for the purposes of artificial insemination - only if rendered in conjunction 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	$680.10
13290	Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required	$321.60
13292	Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.)	$643.60
	Paediatric and neonatal	
13300	Umbilical or scalp vein catheterisation in a neonate with or without infusion; or cannulation of a vein	$89.70
13303	Umbilical artery catheterisation with or without infusion	$133.00
13306	Blood transfusion with venesection and complete replacement of blood, including collection from donor	$525.90
13309	Blood transfusion with venesection and complete replacement of blood, using blood already collected	$448.60
13312	Blood for pathology test, collection of, by femoral or external jugular vein puncture in infants	$44.70
13318	Central vein catheterisation - by open exposure, in a person under 12 years of age (Anaes.)	$358.10
13319	Central vein catheterisation in a neonate via peripheral vein (Anaes.)	$358.10
	Cardiovascular	
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.)	$150.30
	Gastroenterology	
13500	Gastric hypothermia by closed circuit circulation of refrigerant in the absence of gastrointestinal haemorrhage	$269.70
13503	Gastric hypothermia by closed circuit circulation of refrigerant for upper gastrointestinal haemorrhage	$532.70
13506	Gastro-oesophageal balloon intubation, minnesota, sengstaken-blakemore or similar, for control of bleeding from gastric oesophageal varices	$290.90
	Haematology	
13700	Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (Anaes.)	$490.40

13703	Administration of blood including collection from donor	$178.90
13706	Administration of blood or bone marrow already collected	$122.20
13709	Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation	$72.40
13750	Therapeutic haemapheresis for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies - each day	$200.10
13755	Donor haemapheresis for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - each day	$200.10
13757	Therapeutic venesection for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	$96.70
13760	In vitro processing (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: .chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . Acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; or . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day.	$1,126.70
	Procedures associated with intensive care and cardiopulmonary support	
13815	Central vein catheterisation by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.)	$127.80
13818	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)	$197.30
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day	$111.40
13839	Arterial puncture and collection of blood for diagnostic purposes	$36.40
13842	Intra-arterial cannulation for the purpose of taking multiple arterial blood samples for blood gas analysis	$101.10
13847	Counterpulsation by intraaortic balloon management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.)	$268.70
13848	Counterpulsation by intraaortic balloon management on each day subsequent to the first, including associated consultations and monitoring of parameters	$204.90
13851	Circulatory support device, management of, on first day	$795.80
13854	Circulatory support device, management of, on each day subsequent to the first	$184.40
13857	Airway access, establishment of and initiation of mechanical ventilation (other than in the context an anaesthetic for surgery), outside of an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit	$228.00

Management and procedures undertaken in an intensive care unit

13870	Management of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day	$497.40
13873	Management of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day	$364.50
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)	$102.20
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	$252.00
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	$198.40
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	$264.20
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	$139.40

Chemotherapeutic procedures

13915	Cytotoxic chemotherapy, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (uhf radiowave) cancer therapy alone	$105.30
13918	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day	$144.90
13921	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment	$164.60
13924	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode	$96.20
13927	Cytotoxic chemotherapy, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day	$126.30
13930	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day	$176.20
13933	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment	$193.30
13936	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode	$126.30
13939	Implanted pump or reservoir, loading of, with a cytotoxic agent or agents, not being a	$144.90

	service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies	
13942	Ambulatory drug delivery device, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra- arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies	$96.20
13945	Long-term implanted drug delivery device for cytotoxic chemotherapy, accessing of	$77.90
13948	Cytotoxic agent, instillation of, into a body cavity	$96.20
	Dermatology	
14050	PUVA therapy or UVB therapy administered in whole body cabinet (not being a service associated with a service to which item 14053 applies) including associated consultations other than an initial consultation	$83.50
14053	PUVA therapy or UVB therapy administered to localised body areas in a hand and foot cabinet (not being a service associated with a service to which item 14050 applies) including associated consultations other than an initial consultation	$83.50
14100	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of vascular lesions of the head or neck where abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period (Anaes.)	$405.40
14106	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), where the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm2 (Anaes.)	$405.40
14109	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm2 and up to 100cm2 (Anaes.)	$488.90
14112	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm2 and up to 150cm2 (Anaes.)	$586.50
14115	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm2 and up to 250cm2 (Anaes.)	$596.00
14118	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm2 (Anaes.)	$835.20
14124	Laser photocoagulation using laser light within the wave length of 510- 1064nm in the treatment of haemangiomas of infancy, including any associated consultation - where a 7th	$322.00

	or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period (Anaes.)	
	Other therapeutic procedures	
14200	Gastric lavage in the treatment of ingested poison	$101.60
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	$368.70
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	$186.50
14203	Hormone or living tissue implantation, by direct implantation involving incision and suture (Anaes.)	$77.90
14206	Hormone or living tissue implantation by cannula	$49.90
14209	Intraarterial infusion or retrograde intravenous perfusion of a sympatholytic agent	$136.60
14212	Intussusception, management of fluid or gas reduction for (Anaes.)	$293.30
14215	Long-term implanted reservoir associated with the adjustable gastric band, accessing of to add or remove fluid	$155.00
14218	Implanted infusion pump of reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re- programming of a programmable pump, for the management of chronic intractable pain	$150.30
14221	Long-term implanted device for delivery of therapeutic agents, accessing of, not being a service associated with a service to which item 13945 applies	$84.70
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	$108.00
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	$154.10
14230	Intrathecal or epidural spinal catheter insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Assist.) (Anaes.)	$469.30
14233	Infusion pump, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Assist.) (Anaes.)	$569.80
14236	Infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Assist.) (Anaes.)	$1,039.10
14239	Removal of subcutaneously implanted infusion pump, or removal or repositioning of intrathecal or epidural spinal catheter, for the management of severe chronic spasticity (Anaes.)	$251.10
14242	Subcutaneous reservoir and spinal catheter, insertion of, for the management of severe chronic spasticity (Anaes.)	$745.70
14245	Immunomodulating agent, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme	$154.10

GROUP T2 - RADIATION ONCOLOGY

Superficial

15000	Radiotherapy, superficial (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given 1 field	$67.40
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 Derived fee: The fee for item 15000 ($67.40) plus for each field in excess of 1, an amount of $38.60	DF
15006	Radiotherapy, superficial attendance at which a single dose technique is applied - 1 field	$189.80
15009	Radiotherapy, superficial attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields Derived fee: The fee for item 15006 ($189.80) plus each field in excess of 1, an amount of $41.80.	DF
15012	Radiotherapy, superficial each attendance at which treatment is given to an eye	$98.70

Orthovoltage

15100	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field	$75.50
15103	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15100 ($75.50) plus for each field in excess of 1, and amount of $42.50.	DF
15106	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field	$89.20
15109	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15106 ($89.20) plus for each field in excess of 1, an amount of $51.30.	DF
15112	Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 1 field	$190.30
15115	Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15112 ($190.30) plus for each field in excess of 1, an amount of $106.70.	DF

Megavoltage

15211	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given 1 field	$84.00
15214	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit - each	DF

	attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15211 ($84.00) plus for each field in excess of 1, an amount of $52.20.	
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)	$94.40
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)	$94.40
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)	$94.40
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	$96.20
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	$96.20
15230	Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) Derived fee: The fee for item 15215 ($94.40) plus for each field in excess of 1, an amount of $62.60.	DF
15233	Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) Derived fee: The fee for item 15218 ($94.40) plus for each field in excess of 1, an amount of $62.60.	DF
15236	Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) Derived fee: The fee for item 15221 ($94.40) plus for each field in excess of 1, an amount of $62.60.	DF
15239	Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 Derived fee: The fee for item 15224 ($96.20) plus for each field in excess of 1, an amount of $62.60.	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

	Derived fee: The fee for item 15227 ($96.20) plus for each field in excess of 1, an amount of $62.60.	
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)	$96.20
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)	$94.40
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)	$96.20
15254	Radiation oncology treatment, using a 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	$96.20
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	$96.20
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) Derived fee: The fee for item 15245 ($96.20) plus for each field in excess of 1, an amount of $62.60.	DF
15263	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) Derived fee: The fee for item 15248 ($94.40) plus for each field in excess of 1, an amount of $62.60.	DF
15266	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) Derived fee: The fee for item 15251 ($96.20) plus for each field in excess of 1, an amount of $62.60.	DF
15269	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 Derived fee: The fee for item 15254 ($96.20) plus for each field in excess of 1, an amount of $62.60.	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

Derived fee: The fee for item 15257 ($96.20) plus for each field in excess of 1, an amount of $62.60.

Brachytherapy

15303	Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$565.00
15304	Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$565.00
15307	Intrauterine treatment alone using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	$1,071.10
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.)	$1,071.10
15311	Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$527.40
15312	Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$523.50
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.)	$1,035.40
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.)	$1,045.70
15319	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$642.60
15320	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$642.60
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.)	$1,142.60
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.)	$1,165.00
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.)	$1,243.10
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.)	$1,625.00
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.)	$1,180.20
15332	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.)	$1,459.60

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.)	$1,071.10
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.)	$1,071.10
15338	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages t1 (clinically inapparent tumour not palpable or visible by imaging) or t2 (tumour confined within prostate), with a gleason score of less than or equal to 7 and a prostate specific antigen (psa) of less than or equal to 10ng/ml at the time of diagnosis. the procedure must be performed at an approved site in association with a urologist.	$1,728.90
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	$301.20
15345	Construction and application of a radioactive mould using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites	$816.80
15348	Subsequent applications of radioactive mould referred to in item 15342 or 15345 each attendance	$93.60
15351	Construction with or without first application of a radioactive mould not exceeding 5 cm in diameter to an external surface	$231.80
15354	Construction and first application of a radioactive mould more than 5 cm in diameter to an external surface	$223.80
15357	Attendance upon a patient to apply a radioactive mould constructed for application to an external surface of the patient other than an attendance which is the first attendance to apply the mould each attendance	$79.50

Computerised planning

15500	Radiation field setting using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies)	$348.20
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)	$476.00
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)	$745.90
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)	$331.50
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)	$310.70

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	$575.00
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)	$572.90
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	$146.60
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	$618.20
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	$1,142.40
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	$125.10
15530	Radiation Dosimetry by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used	$490.40
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	$965.70
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	$1,490.00
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	$796.20
15553	Simulation for three dimensional conformal radiotherapy pre and post intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable ct image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality ct-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images	$814.30
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	$782.50

	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	
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	$1,045.40
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	$1,447.60
	Stereotactic radiosurgery	
15600	Stereotactic radiosurgery, including all radiation oncology consultations, planning, simulation, dosimetry and treatment	$3,655.00

GROUP T2 - RADIATION ONCOLOGY

	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).	$76.50
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).	$127.70

15710	Radiation oncology treatment verification - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance). (see para t2.5 of explanatory notes to this category)	$128.20

GROUP T2 - RADIATION ONCOLOGY

Brachytherapy planning and verification

15800	Brachytherapy treatment verification - maximum of one only for each attendance.	$168.30
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.)	$1,065.40
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	$816.80
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	$539.80
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	$467.20
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	$5,696.00
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	$3,036.30

GROUP T4 - OBSTETRICS

16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; (b) or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the act applies Derived Fee: 50% of the fee for the associated item.	DF
16400	Antenatal service provided by a midwife, nurse or an aboriginal and torres strait islander health practitioner if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area rrma 3-7; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; andto a maximum of 10 service per pregnancy	$39.10
16401	Obstetric specialist, referred consultation - surgery or hospital professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of	$187.10

	obstetrics, after referral of the patient to him or her - each initial attendance, in a single course of treatment - not being a service to which item 104 applies.	
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.	$78.30
16406	32-36 week obstetric visitantenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. payable only once for a pregnancy.	$208.40
16500	Antenatal attendance	$81.90
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	$221.30
16502	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$73.30
16504	Treatment of habitual miscarriage by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance	$67.40
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	$78.60
16508	Pregnancy complicated by acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$73.20
16509	Preeclampsia, eclampsia or antepartum haemorrhage, treatment of each attendance that is not a routine antenatal attendance	$84.40
16511	Cervix, purse string ligation of (Anaes.)	$416.00
16512	Cervix, removal of purse string ligature of (Anaes.)	$113.10
16514	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement)	$57.80
16515	Management of vaginal delivery as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.)	$1,164.90
16518	Management of labour, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.)	$1,040.80
16519	Management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)	$1,788.60
16520	Caesarean section and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)	$1,933.50
16522	Management of labour and delivery, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management one, or more, of the following conditions is present, including postnatal care for 7 days:. multiple pregnancy; recurrent antepartum haemorrhage from 20 weeks gestation; grades 2, 3 or 4 placenta praevia; baby with a birth weight less than or equal to 2500gm; pre-existing	$2,468.40

	diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; . trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; pre- existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mm Hg associated with at least 1+ proteinuria on urinalysis; prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; or . conditions that pose a significant risk of maternal death. (Anaes.)	
16525	Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.)	$917.20
16527	Management of vaginal delivery, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery. payable once only for a pregnancy. (Anaes.)	$701.30
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.)	$1,262.10
16564	Evacuation of retained products of conception (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	$389.60
16567	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (Anaes.)	$548.70
16570	Acute inversion of the uterus, vaginal correction of, as an independent procedure (Anaes.)	$678.20
16571	Cervix, repair of extensive laceration or lacerations (Anaes.)	$585.80
16573	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)	$442.50
16590	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies.	$337.60
16591	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies.	$225.70
16600	Amniocentesis, diagnostic	$153.00
16603	Chorionic villus sampling, by any route	$221.60
16606	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)	$383.00
16609	Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.)	$781.00
16612	Fetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)	$614.40
16615	Fetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)	$327.40
16618	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500ml being aspirated	$331.80

16621	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios	$327.40
16624	Fetal fluid filled cavity, drainage of	$471.00
16627	Feto-amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis	$958.80
16633	Procedure on multiple pregnancies relating to items 16606, 16609, 16612, 16615 and 16627 Derived Fee: 50% of the fee for the first foetus for any additional foetus tested	DF
16636	Procedure on multiple pregnancies relating to items 16600, 16603, 16618, 16621 and 16624 Derived Fee: 50% of the fee for the first foetus for any additional foetus tested	DF

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 practitioner in the practice of anaesthesia) a brief consultation involving a targeted history and limited examination (including the cardio-respiratory system) and of not more than 15 minutes s duration, not being a service associated with a service to which items 2801 - 3000 apply	$80.70
17615	A consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies	$155.80
17620	A consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	$214.50
17625	A consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes - and of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	$274.10
17640	Anaesthetist, consultation (other than prior to anaesthesia) (Professional attendance by a specialist anaesthetist in the practice of anaesthesia where the patient is referred to him or her) - a brief consultation involving a short history and limited examination - and of not more than 15 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	$77.80

17645	A consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan - and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply.	$142.00
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	$198.50
17655	A consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity, - and of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply.	$271.30
17680	Anaesthetist, consultation, other (Professional attendance by an anaesthetist in the practice of anaesthesia) - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply.	$169.20
17690	- Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-rooms if: (a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes duration not being a service associated with a service to which items 2801 - 3000 apply.	$62.60

GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS

18213	Intravenous regional anaesthesia of limb by retrograde perfusion	$141.40
18216	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)	$373.90
18219	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) Derived fee: The fee for item 18216 ($373.90) plus $36.50 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.	DF
18222	Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less	$91.10
18225	Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes	$127.50
18226	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.	$574.50
18227	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a saturday, a sunday or a public holiday.	DF

	Derived fee: The fee for item 18226 ($574.50) plus $45.60 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.	
18228	Interpleural block, initial injection or commencement of infusion of a therapeutic substance	$155.20
18230	Intrathecal or epidural injection of neurolytic substance (Anaes.)	$437.30
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.)	$315.80
18233	Epidural injection of blood for blood patch (Anaes.)	$328.10
18234	Trigeminal nerve, primary division of, injection of an anaesthetic agent (Anaes.)	$205.00
18236	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent (Anaes.)	$117.90
18238	Facial nerve, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies	$59.80
18240	Retrobulbar or peribulbar injection of an anaesthetic agent	$183.30
18242	Greater occipital nerve, injection of an anaesthetic agent (Anaes.)	$71.80
18244	Vagus nerve, injection of an anaesthetic agent	$241.40
18246	Glossopharyngeal nerve, injection of an anaesthetic agent	$181.70
18248	Phrenic nerve, injection of an anaesthetic agent	$166.00
18250	Spinal accessory nerve, injection of an anaesthetic agent	$162.40
18252	Cervical plexus, injection of an anaesthetic agent	$186.30
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, injection of an anaesthetic agent	$203.00
18266	Ulnar, radial or median nerve, main trunk of, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block	$144.70
18268	Obturator nerve, injection of an anaesthetic agent	$176.90
18270	Femoral nerve, injection of an anaesthetic agent	$319.80
18272	Saphenous, sural, popliteal or posterior tibial nerve, main trunk of, 1 or more of, injection of an anaesthetic agent	$183.30
18274	Paravertebral, cervical, thoracic, lumbar, sacral or coccygeal nerves, injection of an anaesthetic agent, (single vertebral level)	$180.10
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels)	$249.40
18278	Sciatic nerve, injection of an anaesthetic agent	$192.30
18280	Sphenopalatine ganglion, injection of an anaesthetic agent (Anaes.)	$258.10
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.)	$395.30
18292	Nerve branch, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which items 18354, 18356 and 18358 applies (Anaes.)	$269.40
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent (Anaes.)	$315.70
18296	Lumbar sympathetic chain, destruction by a neurolytic agent (Anaes.)	$318.00
18298	Cervical or thoracic sympathetic chain, destruction by a neurolytic agent (Anaes.)	$278.40

GROUP T11 - BOTULINUM TOXIN INJECTIONS

18350	Botulinum toxin (Botox), injection of, for hemifacial spasm in a patient 12 years of age or older, including all injections on any one day	$198.90
18351	Botulinum toxin (Dysport), injection of, for the treatment of hemifacial spasm in a patient 18 years of age or older, including all such injections on any one day	$215.00
18352	Botulinum toxin (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day	$395.30
18354	Botulinum toxin (botox or dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument pb 122 of 2008 (arrangements - botulinum toxin program) made under section 100 (1) (b) of the national health act 1953, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.)	$214.50
18356	Botulinum toxin (botox or dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument pb 122 of 2008 (arrangements - botulinum toxin program) made under section 100 (1) (b) of the national health act 1953, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.)	$196.50
18358	Botulinum toxin (botox or dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument pb 122 of 2008 (arrangements - botulinum toxin program) made under section 100 (1) (b) of the national health act 1953, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.)	$196.50
18360	Botulinum toxin (Botox), injection of, for the treatment of focal spasticity in adults, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb)	$197.60
18361	Botulinum toxin (botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy, in a patient who is at least 2 years but less than 18 years, in association with either: (a) physiotherapy or occupational therapy or both; or (b) electrical stimulation or ultrasound for muscle localisation; including all injections for any or all of the muscles sub-serving one functional activity supplied by one motor nerve - with a maximum of four treatments per patient on any one day, and with a maximum of two treatments per limb (Anaes.)	$194.30
18362	Botulinum toxin (Botox), injection of, for the treatment of severe primary hyperhidrosis of the axillae, including all such injections on any one day (Anaes.)	$496.00

18364	Botulinum toxin (Dysport), injection of, for treatment of spasticity of the arm in adults following a stroke, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb)	$198.40
18366	Botulinum toxin (Botox), injection of, for the treatment of strabismus in children and adults, including all such injections on any one day and associated electromyography (Anaes.)	$303.50
18368	Botulinum toxin (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day	$422.60
18370	Botulinum toxin (Botox), injection of, for the treatment of blepharospasm in a patient 12 years of age or older, including all such injections on any one day. (Anaes.)	$75.00
18371	Botulinum toxin (Dysport), injection of, for the treatment of blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.)	$92.00
18372	Botulinum toxin (Botox), injection of, for the treatment of essential (bilateral) blepharospasm in a patient 12 years of age or older, including all such injections on any one day (Anaes.)	$196.50
18373	Botulinum toxin (Dysport), injection of, for the treatment of bilateral blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.)	$196.50

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 (005) (basic units)	$264.50
20102	Initiation of management of anaesthesia for plastic repair of cleft lip (006) (basic units)	$317.40
20104	Initiation of management of anaesthesia for electroconvulsive therapy (004) (basic units)	$211.60
20120	Initiation of management of anaesthesia for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this subgroup applies (005) (basic units)	$264.50
20124	Initiation of management of anaesthesia for otoscopy (004) (basic units)	$211.60
20140	Initiation of management of anaesthesia for procedures on eye, not being a service to which another item in this group applies (005) (basic units)	$264.50
20142	Initiation of management of anaesthesia for lens surgery (006) (basic units)	$317.40
20143	Initiation of management of anaesthesia for retinal surgery (006) (basic units)	$317.40
20144	Initiation of management of anaesthesia for corneal transplant (008) (basic units)	$423.20
20145	Initiation of management of anaesthesia for vitrectomy (008) (basic units)	$423.20
20146	Initiation of management of anaesthesia for biopsy of conjunctiva (005) (basic units)	$264.50
20147	Initiation of management of anaesthesia for squint repair (006) (basic units)	$317.40
20148	Initiation of management of anaesthesia for ophthalmoscopy (004) (basic units)	$211.60
20160	Initiation of management of anaesthesia for procedures on nose or accessory sinuses, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
20162	Initiation of management of anaesthesia for radical surgery on the nose and accessory sinuses (007) (basic units)	$370.30

20164	Initiation of management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses (004) (basic units)	$211.60
20170	Initiation of management of anaesthesia for intraoral procedures, including biopsy, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
20172	Initiation of management of anaesthesia for repair of cleft palate (007) (basic units)	$370.30
20174	Initiation of management of anaesthesia for excision of retropharyngeal tumour (009) (basic units)	$476.10
20176	Initiation of management of anaesthesia for radical intraoral surgery (010) (basic units)	$529.00
20190	Initiation of management of anaesthesia for procedures on facial bones, not being a service to which another item in this subgroup applies (005) (basic units)	$264.50
20192	Initiation of management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (010) (basic units)	$529.00
20210	Initiation of management of anaesthesia for intracranial procedures, not being a service to which another item in this subgroup applies (015) (basic units)	$793.50
20212	Initiation of management of anaesthesia for subdural taps (005) (basic units)	$264.50
20214	Initiation of management of anaesthesia for burr holes of the cranium (009) (basic units)	$476.10
20216	Initiation of management of anaesthesia for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (020) (basic units)	$1,058.00
20220	Initiation of management of anaesthesia for spinal fluid shunt procedures (010) (basic units)	$529.00
20222	Initiation of management of anaesthesia for ablation of an intracranial nerve (006) (basic units)	$317.40
20225	Initiation of management of anaesthesia for all cranial bone procedures (012) (basic units)	$634.80
20230	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the head or face (012) (basic units)	$634.80

Neck

20300	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (005) (basic units)	$264.50
20305	Initiation of management of anaesthesia for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (015) (basic units)	$793.50
20320	Initiation of management of anaesthesia for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
20321	Initiation of management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (010) (basic units)	$529.00
20330	Initiation of management of anaesthesia for laser surgery to the airway (excluding nose and mouth) (008) (basic units)	$423.20
20350	Initiation of management of anaesthesia for procedures on major vessels of neck, not being a service to which another item in this subgroup applies (010) (basic units)	$529.00
20352	Initiation of management of anaesthesia for simple ligation of major vessels of neck (005) (basic units)	$264.50
20355	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the neck (012) (basic units)	$634.80

Thorax

20400	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this subgroup applies (003) (basic units)	$158.70
20401	Initiation of management of anaesthesia for procedures on the breast, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
20402	Initiation of management of anaesthesia for reconstructive procedures on breast (005) (basic units)	$264.50
20403	Initiation of management of anaesthesia for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (005) (basic units)	$264.50
20404	Initiation of management of anaesthesia for mastectomy (006) (basic units)	$317.40
20405	Initiation of management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps (008) (basic units)	$423.20
20406	Initiation of management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection (013) (basic units)	$687.70
20410	Initiation of management of anaesthesia for electrical conversion of arrhythmias (005) (basic units)	$264.50
20420	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (005) (basic units)	$264.50
20440	Initiation of management of anaesthesia for percutaneous bone marrow biopsy of the sternum (004) (basic units)	$211.60
20450	Initiation of management of anaesthesia for procedures on clavicle, scapula or sternum, not being a service to which another item in this subgroup applies (005) (basic units)	$264.50
20452	Initiation of management of anaesthesia for radical surgery on clavicle, scapula or sternum (006) (basic units)	$317.40
20470	Initiation of management of anaesthesia for partial rib resection, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
20472	Initiation of management of anaesthesia for thoracoplasty (010) (basic units)	$529.00
20474	Initiation of management of anaesthesia for radical procedures on chest wall (013) (basic units)	$687.70
20475	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax (010) (basic units)	$529.00

Intrathoracic

20500	Initiation of management of anaesthesia for open procedures on the oesophagus (015) (basic units)	$793.50
20520	Initiation of management of anaesthesia for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (006) (basic units)	$317.40
20522	Initiation of management of anaesthesia for needle biopsy of pleura (004) (basic units)	$211.60
20524	Initiation of management of anaesthesia for pneumocentesis (004) (basic units)	$211.60
20526	Initiation of management of anaesthesia for thoracoscopy (010) (basic units)	$529.00
20528	Initiation of management of anaesthesia for mediastinoscopy (008) (basic units)	$423.20
20540	Initiation of management of anaesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this	$687.70

	subgroup applies (013) (basic units)	
20542	Initiation of management of anaesthesia for pulmonary decortication (015) (basic units)	$793.50
20546	Initiation of management of anaesthesia for pulmonary resection with thoracoplasty (015) (basic units)	$793.50
20548	Initiation of management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi (015) (basic units)	$793.50
20560	Initiation of management of anaesthesia for open procedures on the heart, pericardium or great vessels of chest (020) (basic units)	$1,058.00
	Spine and spinal cord	
20600	Initiation of management of anaesthesia for procedures on cervical spine and/or cord, not being a service to which another item in this subgroup applies (for myelography and discography see Items 21908 and 21914) (010) (basic units)	$529.00
20604	Initiation of management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position (013) (basic units)	$687.70
20620	Initiation of management of anaesthesia for procedures on thoracic spine and/or cord, not being a service to which another item in this subgroup applies (010) (basic units)	$529.00
20622	Initiation of management of anaesthesia for thoracolumbar sympathectomy (013) (basic units)	$687.70
20630	Initiation of management of anaesthesia for procedures in lumbar region, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
20632	Initiation of management of anaesthesia for lumbar sympathectomy (007) (basic units)	$370.30
20634	Initiation of management of anaesthesia for chemonucleolysis (010) (basic units)	$529.00
20670	Initiation of management of anaesthesia for extensive spine and/or spinal cord procedures (013) (basic units)	$687.70
20680	Initiation of management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital (003) (basic units)	$158.70
20690	Initiation of management of anaesthesia for percutaneous spinal procedures, not being a service to which another item in this subgroup applies (005) (basic 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 (003) (basic units)	$158.70
20702	Initiation of management of anaesthesia for percutaneous liver biopsy (004) (basic units)	$211.60
20703	Initiation of management of anaesthesia for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (004) (basic units)	$211.60
20704	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (010) (basic units)	$529.00
20705	Initiation of management of anaesthesia for diagnostic laparoscopy procedures (006) (basic units)	$317.40
20706	Initiation of management of anaesthesia for laparoscopic procedures in the upper abdomen, not being a service to which another item in this subgroup applies (007) (basic units)	$370.30
20730	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this subgroup applies (005) (basic units)	$264.50

20740	Initiation of management of anaesthesia for upper gastrointestinal endoscopic procedures (005) (basic units)	$264.50
20745	Initiation of management of anaesthesia for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (006) (basic units)	$317.40
20750	Initiation of management of anaesthesia for hernia repairs in upper abdomen, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
20752	Initiation of management of anaesthesia for repair of incisional hernia and/or wound dehiscence (006) (basic units)	$317.40
20754	Initiation of management of anaesthesia for procedures on an omphalocele (007) (basic units)	$370.30
20756	Initiation of management of anaesthesia for transabdominal repair of diaphragmatic hernia (009) (basic units)	$476.10
20770	Initiation of management of anaesthesia for procedures on major upper abdominal blood vessels (015) (basic units)	$793.50
20790	Initiation of management of anaesthesia for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (008) (basic units)	$423.20
20791	Initiation of management of anaesthesia for gastric reduction or gastroplasty for the treatment of morbid obesity (010) (basic units)	$529.00
20792	Initiation of management of anaesthesia for partial hepatectomy (excluding liver biopsy) (013) (basic units)	$687.70
20793	Initiation of management of anaesthesia for extended or trisegmental hepatectomy (015) (basic units)	$793.50
20794	Initiation of management of anaesthesia for pancreatectomy, partial or total (012) (basic units)	$634.80
20798	Initiation of management of anaesthesia for neuro endocrine tumour removal in the upper abdomen (010) (basic units)	$529.00
20799	Initiation of management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the upper abdomen (006) (basic units)	$317.40
	Lower abdomen	
20800	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this subgroup applies (003) (basic units)	$158.70
20802	Initiation of management of anaesthesia for lipectomy of the lower abdomen (005) (basic units)	$264.50
20803	Initiation of management of anaesthesia for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (004) (basic units)	$211.60
20804	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (010) (basic units)	$529.00
20805	Initiation of management of anaesthesia for diagnostic laparoscopic procedures (006) (basic units)	$317.40
20806	Initiation of management of anaesthesia for laparoscopic procedures in the lower abdomen (007) (basic units)	$370.30
20810	Initiation of management of anaesthesia for lower intestinal endoscopic procedures (004) (basic units)	$211.60

20815	Initiation of management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract (006) (basic units)	$317.40
20820	Initiation of management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (005) (basic units)	$264.50
20830	Initiation of management of anaesthesia for hernia repairs in lower abdomen, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
20832	Initiation of management of anaesthesia for repair of incisional herniae and/or wound dehiscence of the lower abdomen (006) (basic units)	$317.40
20840	Initiation of management of anaesthesia for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
20841	Initiation of management of anaesthesia for bowel resection, including laparoscopic bowel resection not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
20842	Initiation of management of anaesthesia for amniocentesis (004) (basic units)	$211.60
20844	Initiation of management of anaesthesia for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (010) (basic units)	$529.00
20845	Initiation of management of anaesthesia for radical prostatectomy (010) (basic units)	$529.00
20846	Initiation of management of anaesthesia for radical hysterectomy (010) (basic units)	$529.00
20847	Initiation of management of anaesthesia for ovarian malignancy (010) (basic units)	$529.00
20848	Initiation of management of anaesthesia for pelvic exenteration (010) (basic units)	$529.00
20850	Initiation of management of anaesthesia for caesarean section (012) (basic units)	$634.80
20855	Initiation of management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of delivery. (015) (basic units)	$793.50
20860	Initiation of management of anaesthesia for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
20862	Initiation of management of anaesthesia for renal procedures, including upper 1/3 of ureter (007) (basic units)	$370.30
20863	Initiation of management of anaesthesia for nephrectomy (010) (basic units)	$529.00
20864	Initiation of management of anaesthesia for total cystectomy (010) (basic units)	$529.00
20866	Initiation of management of anaesthesia for adrenalectomy (010) (basic units)	$529.00
20867	Initiation of management of anaesthesia for neuro endocrine tumour removal in the lower abdomen (010) (basic units)	$529.00
20868	Initiation of management of anaesthesia for renal transplantation (donor or recipient) (010) (basic units)	$529.00
20880	Initiation of management of anaesthesia for procedures on major lower abdominal vessels, not being a service to which another item in this Subgroup applies (015) (basic units)	$793.50
20882	Initiation of management of anaesthesia for inferior vena cava ligation (010) (basic units)	$529.00
20884	Initiation of management of anaesthesia for percutaneous umbrella insertion (005) (basic units)	$264.50
20886	Initiation of management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the lower abdomen (006) (basic units)	$317.40

Perineum

20900	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the perineum (including biopsy of male genital system), not being a service to which another item in this subgroup applies (003) (basic units)	$158.70
20902	Initiation of management of anaesthesia for anorectal procedures (including endoscopy and/or biopsy) (004) (basic units)	$211.60
20904	Initiation of management of anaesthesia for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (007) (basic units)	$370.30
20905	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the perineum (010) (basic units)	$529.00
20906	Initiation of management of anaesthesia for vulvectomy (004) (basic units)	$211.60
20910	Initiation of management of anaesthesia for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
20911	Initiation of management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures (005) (basic units)	$264.50
20912	Initiation of management of anaesthesia for transurethral resection of bladder tumour(s) (005) (basic units)	$264.50
20914	Initiation of management of anaesthesia for transurethral resection of prostate (007) (basic units)	$370.30
20916	Initiation of management of anaesthesia for bleeding post- transurethral resection (007) (basic units)	$370.30
20920	Initiation of management of anaesthesia for procedures on male external genitalia, not being a service to which another item in this Subgroup applies (004) (basic units)	$211.60
20924	Initiation of management of anaesthesia for procedures on undescended testis, unilateral or bilateral (004) (basic units)	$211.60
20926	Initiation of management of anaesthesia for radical orchidectomy, inguinal approach (004) (basic units)	$211.60
20928	Initiation of management of anaesthesia for radical orchidectomy, abdominal approach (006) (basic units)	$317.40
20930	Initiation of management of anaesthesia for orchiopexy, unilateral or bilateral (004) (basic units)	$211.60
20932	Initiation of management of anaesthesia for complete amputation of penis (004) (basic units)	$211.60
20934	Initiation of management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy (006) (basic units)	$317.40
20936	Initiation of management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (008) (basic units)	$423.20
20938	Initiation of management of anaesthesia for insertion of penile prosthesis (004) (basic units)	$211.60
20940	Initiation of management of anaesthesia for per vagina and vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (004) (basic units)	$211.60
20942	Initiation of management of anaesthesia for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (005) (basic units)	$264.50
20943	Initiation of management of anaesthesia for transvaginal assisted reproductive services (004) (basic units)	$211.60

20944	Initiation of management of anaesthesia for vaginal hysterectomy (006) (basic units)	$317.40
20946	Initiation of management of anaesthesia for vaginal delivery (008) (basic units)	$423.20
20948	Initiation of management of anaesthesia for purse string ligation of cervix, or removal of purse string ligature, or removal of purse string ligature (004) (basic units)	$211.60
20950	Initiation of management of anaesthesia for culdoscopy (005) (basic units)	$264.50
20952	Initiation of management of anaesthesia for hysteroscopy (004) (basic units)	$211.60
20953	Initiation of management of anaesthesia for endometrial ablation or resection in association with hysteroscopy (005) (basic units)	$264.50
20954	Initiation of management of anaesthesia for correction of inverted uterus (010) (basic units)	$529.00
20956	Initiation of management of anaesthesia for evacuation of retained products of conception, as a complication of confinement (004) (basic units)	$211.60
20958	Initiation of management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery (005) (basic units)	$264.50
20960	Initiation of management of anaesthesia for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (007) (basic units)	$370.30

Pelvis (except hip)

21100	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (003) (basic units)	$158.70
21110	Initiation of management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (005) (basic units)	$264.50
21112	Initiation of management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest (004) (basic units)	$211.60
21114	Initiation of management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest (005) (basic units)	$264.50
21116	Initiation of management of anaesthesia for percutaneous bone marrow harvesting from the pelvis (006) (basic units)	$317.40
21120	Initiation of management of anaesthesia for procedures on the bony pelvis (006) (basic units)	$317.40
21130	Initiation of management of anaesthesia for body cast application or revision when performed in the operating theatre of a hospital (003) (basic units)	$158.70
21140	Initiation of management of anaesthesia for interpelviabdominal (hind-quarter) amputation (015) (basic units)	$793.50
21150	Initiation of management of anaesthesia for radical procedures for tumour of the pelvis, except hind-quarter amputation (010) (basic units)	$529.00
21155	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior pelvis (010) (basic units)	$529.00
21160	Initiation of management of anaesthesia for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (004) (basic units)	$211.60
21170	Initiation of management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint (008) (basic units)	$423.20

Upper leg (except knee)

21195	Initiation of management of anaesthesia for procedures on the skins or subcutaneous tissue of the upper leg (003) (basic units)	$158.70

21199	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (004) (basic units)	$211.60
21200	Initiation of management of anaesthesia for closed procedures involving hip joint when performed in the operating theatre of a hospital (004) (basic units)	$211.60
21202	Initiation of management of anaesthesia for arthroscopic procedures of the hip joint (004) (basic units)	$211.60
21210	Initiation of management of anaesthesia for open procedures involving hip joint, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
21212	Initiation of management of anaesthesia for hip disarticulation (010) (basic units)	$529.00
21214	Initiation of management of anaesthesia for total hip replacement or revision (010) (basic units)	$529.00
21216	Initiation of management of anaesthesia for bilateral total hip replacement (014) (basic units)	$740.60
21220	Initiation of management of anaesthesia for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (004) (basic units)	$211.60
21230	Initiation of management of anaesthesia for open procedures involving upper 2/3 of femur, not being a service to which another item in this subgroup applies (006) (basic units)	$317.40
21232	Initiation of management of anaesthesia for above knee amputation (005) (basic units)	$264.50
21234	Initiation of management of anaesthesia for radical resection of the upper 2/3 of femur (008) (basic units)	$423.20
21260	Initiation of management of anaesthesia for procedures involving veins of upper leg, including exploration (004) (basic units)	$211.60
21270	Initiation of management of anaesthesia for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
21272	Initiation of management of anaesthesia for femoral artery ligation (004) (basic units)	$211.60
21274	Initiation of management of anaesthesia for femoral artery embolectomy (006) (basic units)	$317.40
21275	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the upper leg (010) (basic units)	$529.00
21280	Initiation of management of anaesthesia for microsurgical reimplantation of upper leg (015) (basic units)	$793.50

Knee and popliteal area

21300	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (003) (basic units)	$158.70
21321	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (004) (basic units)	$211.60
21340	Initiation of management of anaesthesia for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (004) (basic units)	$211.60
21360	Initiation of management of anaesthesia for open procedures on lower 1/3 of femur (005) (basic units)	$264.50
21380	Initiation of management of anaesthesia for closed procedures on knee joint when performed in the operating theatre of a hospital (003) (basic units)	$158.70
21382	Initiation of management of anaesthesia for arthroscopic procedures of knee joint (004) (basic units)	$211.60
21390	Initiation of management of anaesthesia for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (003) (basic	$158.70

	units)	
21392	Initiation of management of anaesthesia for open procedures on upper ends of tibia, fibula, and/or patella (004) (basic units)	$211.60
21400	Initiation of management of anaesthesia for open procedures on knee joint, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21402	Initiation of management of anaesthesia for knee replacement (007) (basic units)	$370.30
21403	Initiation of management of anaesthesia for bilateral knee replacement (010) (basic units)	$529.00
21404	Initiation of management of anaesthesia for disarticulation of knee (005) (basic units)	$264.50
21420	Initiation of management of anaesthesia for cast application, removal, or repair involving knee joint, undertaken in a hospital (003) (basic units)	$158.70
21430	Initiation of management of anaesthesia for procedures on veins of knee or popliteal area, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21432	Initiation of management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area (005) (basic units)	$264.50
21440	Initiation of management of anaesthesia for procedures on arteries of knee or popliteal area, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
21445	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the knee and/or popliteal area (010) (basic units)	$529.00
	Lower leg (below knee)	
21460	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (003) (basic units)	$158.70
21461	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21462	Initiation of management of anaesthesia for all closed procedures on lower leg, ankle, or foot (003) (basic units)	$158.70
21464	Initiation of management of anaesthesia for arthroscopic procedure of ankle joint (004) (basic units)	$211.60
21472	Initiation of management of anaesthesia for repair of achilles tendon (005) (basic units)	$264.50
21474	Initiation of management of anaesthesia for gastrocnemius recession (005) (basic units)	$264.50
21480	Initiation of management of anaesthesia for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21482	Initiation of management of anaesthesia for radical resection of bone involving lower leg, ankle or foot (005) (basic units)	$264.50
21484	Initiation of management of anaesthesia for osteotomy or osteoplasty of tibia or fibula (005) (basic units)	$264.50
21486	Initiation of management of anaesthesia for total ankle replacement (007) (basic units)	$370.30
21490	Initiation of management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital (003) (basic units)	$158.70
21500	Initiation of management of anaesthesia for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
21502	Initiation of management of anaesthesia for embolectomy of the lower leg (006) (basic units)	$317.40

21520	Initiation of management of anaesthesia for procedures on veins of lower leg, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21522	Initiation of management of anaesthesia for venous thrombectomy of the lower leg (005) (basic units)	$264.50
21530	Initiation of management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot (015) (basic units)	$793.50
21532	Initiation of management of anaesthesia for microsurgical reimplantation of toe (008) (basic units)	$423.20
21535	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the lower leg (010) (basic units)	$529.00

Shoulder and axilla

21600	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the shoulder or axilla (003) (basic units)	$158.70
21610	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (005) (basic units)	$264.50
21620	Initiation of management of anaesthesia for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (004) (basic units)	$211.60
21622	Initiation of management of anaesthesia for arthroscopic procedures of shoulder joint (005) (basic units)	$264.50
21630	Initiation of management of anaesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this subgroup applies (005) (basic units)	$264.50
21632	Initiation of management of anaesthesia for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (006) (basic units)	$317.40
21634	Initiation of management of anaesthesia for shoulder disarticulation (009) (basic units)	$476.10
21636	Initiation of management of anaesthesia for interthoracoscapular (forequarter) amputation (015) (basic units)	$793.50
21638	Initiation of management of anaesthesia for total shoulder replacement (010) (basic units)	$529.00
21650	Initiation of management of anaesthesia for procedures on arteries of shoulder or axilla, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
21652	Initiation of management of anaesthesia for procedures for axillary-brachial aneurysm (010) (basic units)	$529.00
21654	Initiation of management of anaesthesia for bypass graft of arteries of shoulder or axilla (008) (basic units)	$423.20
21656	Initiation of management of anaesthesia for axillary-femoral bypass graft (010) (basic units)	$529.00
21670	Initiation of management of anaesthesia for procedures on veins of shoulder or axilla (004) (basic units)	$211.60
21680	Initiation of management of anaesthesia for shoulder cast application, removal or repair, not being a service to which another item in this subgroup applies, when undertaken in a hospital (003) (basic units)	$158.70
21682	Initiation of management of anaesthesia for shoulder spica application when undertaken in a hospital (004) (basic units)	$211.60
21685	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or the axilla (010) (basic units)	$529.00

Upper arm and elbow

21700	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper arm or elbow (003) (basic units)	$158.70
21710	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21712	Initiation of management of anaesthesia for open tenotomy of the upper arm or elbow (005) (basic units)	$264.50
21714	Initiation of management of anaesthesia for tenoplasty of the upper arm or elbow (005) (basic units)	$264.50
21716	Initiation of management of anaesthesia for tenodesis for rupture of long tendon of biceps (005) (basic units)	$264.50
21730	Initiation of management of anaesthesia for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (003) (basic units)	$158.70
21732	Initiation of management of anaesthesia for arthroscopic procedures of elbow joint (004) (basic units)	$211.60
21740	Initiation of management of anaesthesia for open procedures on the upper arm or elbow, not being a service to which another item in this subgroup applies (005) (basic units)	$264.50
21756	Initiation of management of anaesthesia for radical procedures on the upper arm or elbow (006) (basic units)	$317.40
21760	Initiation of management of anaesthesia for total elbow replacement (007) (basic units)	$370.30
21770	Initiation of management of anaesthesia for procedures on arteries of upper arm, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20
21772	Initiation of management of anaesthesia for embolectomy of arteries of the upper arm (006) (basic units)	$317.40
21780	Initiation of management of anaesthesia for procedures on veins of upper arm, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21785	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow (010) (basic units)	$529.00
21790	Initiation of management of anaesthesia for microsurgical reimplantation of upper arm (015) (basic units)	$793.50

Forearm wrist and hand

21800	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (003) (basic units)	$158.70
21810	Initiation of management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (004) (basic units)	$211.60
21820	Initiation of management of anaesthesia for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (003) (basic units)	$158.70
21830	Initiation of management of anaesthesia for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21832	Initiation of management of anaesthesia for total wrist replacement (007) (basic units)	$370.30
21834	Initiation of management of anaesthesia for arthroscopic procedures of the wrist joint (004) (basic units)	$211.60
21840	Initiation of management of anaesthesia for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this subgroup applies (008) (basic units)	$423.20

21842	Initiation of management of anaesthesia for embolectomy of artery of forearm, wrist or hand (006) (basic units)	$317.40
21850	Initiation of management of anaesthesia for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this subgroup applies (004) (basic units)	$211.60
21860	Initiation of management of anaesthesia for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (003) (basic units)	$158.70
21865	Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand (010) (basic units)	$529.00
21870	Initiation of management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand (015) (basic units)	$793.50
21872	Initiation of management of anaesthesia for microsurgical reimplantation of a finger (008) (basic units)	$423.20

Anaesthesia for burns

21878	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (003) (basic units)	$158.70
21879	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves more than 3% but less than 10% of total body surface (005) (basic units)	$264.50
21880	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (007) (basic units)	$370.30
21881	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (009) (basic units)	$476.10
21882	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (011) (basic units)	$581.90
21883	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (013) (basic units)	$687.70
21884	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (015) (basic units)	$793.50
21885	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (017) (basic units)	$899.30
21886	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (019) (basic units)	$1,005.10
21887	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (021) (basic units)	$1,110.90

Anaesthesia for radiological or other diagnostic or therapeutic procedures

21900	Initiation of management of anaesthesia for injection procedure for hysterosalpingography (003) (basic units)	$158.70

21906	Initiation of management of anaesthesia for injection procedure for myelography: lumbar or thoracic (005) (basic units)	$264.50
21908	Initiation of management of anaesthesia for injection procedure for myelography: cervical (006) (basic units)	$317.40
21910	Initiation of management of anaesthesia for injection procedure for myelography: posterior fossa (009) (basic units)	$476.10
21912	Initiation of management of anaesthesia for injection procedure for discography: lumbar or thoracic (005) (basic units)	$264.50
21914	Initiation of management of anaesthesia for injection procedure for discography cervical (006) (basic units)	$317.40
21915	Initiation of management of anaesthesia for peripheral arteriogram (005) (basic units)	$264.50
21916	Initiation of management of anaesthesia for arteriograms: cerebral, carotid or vertebral (005) (basic units)	$264.50
21918	Initiation of management of anaesthesia for retrograde arteriogram: brachial or femoral (005) (basic units)	$264.50
21922	Initiation of management of anaesthesia for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (007) (basic units)	$370.30
21925	Initiation of management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography (004) (basic units)	$211.60
21926	Initiation of management of anaesthesia for fluoroscopy (005) (basic units)	$264.50
21927	Initiation of management of anaesthesia for barium enema or other opaque study of the small bowel (005) (basic units)	$264.50
21930	Initiation of management of anaesthesia for bronchography (006) (basic units)	$317.40
21935	Initiation of management of anaesthesia for phlebography (005) (basic units)	$264.50
21936	Initiation of management of anaesthesia for heart, 2 dimensional real time transoesophageal examination (006) (basic units)	$317.40
21939	Initiation of management of anaesthesia for peripheral venous cannulation (003) (basic units)	$158.70
21941	Initiation of management of anaesthesia for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (007) (basic units)	$370.30
21942	Initiation of management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation (010) (basic units)	$529.00
21943	Initiation of management of anaesthesia for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (005) (basic units)	$264.50
21945	Initiation of management of anaesthesia for lumbar puncture, cisternal puncture, or epidural injection (005) (basic units)	$264.50
21949	Initiation of management of anaesthesia for harvesting of bone marrow for the purpose of transplantation (005) (basic units)	$264.50
21952	Initiation of management of anaesthesia for muscle biopsy for malignant hyperpyrexia (010) (basic units)	$529.00
21955	Initiation of management of anaesthesia for electroencephalography (005) (basic units)	$264.50
21959	Initiation of management of anaesthesia for brain stem evoked response audiometry (005) (basic units)	$264.50

21962	Initiation of management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method (005) (basic units)	$264.50
21965	Initiation of management of anaesthesia as a therapeutic procedure where it can be demonstrated that there is a clinical need for anaesthesia, not for the treatment of headache of any etiology (005) (basic units)	$264.50
21969	Initiation of management of anaesthesia during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (008) (basic units)	$423.20
21970	Initiation of management of anaesthesia during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (015) (basic units)	$793.50
21973	Initiation of management of anaesthesia for brachytherapy using radioactive sealed sources (005) (basic units)	$264.50
21976	Initiation of management of anaesthesia for therapeutic nuclear medicine (005) (basic units)	$264.50
21980	Initiation of management of anaesthesia for radiotherapy (005) (basic units)	$264.50
21981	Anaesthetic agent allergy testing, using skin sensitivity methods in a patient with a history of prior anaphylactic or anaphylactoid reaction or cardiovascular collapse associated with the management of anaesthesia agents (004) (basic units)	$211.60
	Miscellaneous	
21990	Initiation of management of anaesthesia when no procedure ensues (003) (basic units)	$158.70
21992	Initiation of management of anaesthesia performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (004) (basic units)	$211.60
21997	Initiation of management of anaesthesia in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies where it can be demonstrated that there is a clinical need for anaesthesia (004) (basic units)	$211.60
	Therapeutic and diagnostic services	
22001	Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the administration of anaesthesia (003) (basic units)	$158.70
22002	Administration of blood or bone marrow already collected when performed in association with the administration of anaesthesia (004) (basic units)	$211.60
22007	Endotracheal intubation with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (004) (basic units)	$211.60
22008	Double lumen endobronchial tube or bronchial blocker, insertion of when performed in association with the administration of anaesthesia (004) (basic units)	$211.60
22012	Blood pressure monitoring (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) when performed in association with the administration of anaesthesia (003) (basic units)	$158.70
22014	Blood pressure monitoring (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) when performed in association with the administration of anaesthesia relating to another discrete operation on the same day (003) (basic units)	$158.70

22015	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (006) (basic units)	$317.40
22018	Measurement of the mechanical or gas exchange function of the respiratory system, using measurements of parameters, including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood and incorporating serial arterial blood gas analysis and a written record of the results, when performed in association with the administration of anaesthesia, not being a service associated with a service to which item 11503 applies (007) (basic units)	$370.30
22020	Central vein catheterisation by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (004) (basic units)	$211.60
22025	Intraarterial cannulation when performed in association with the administration of anaesthesia (004) (basic units)	$211.60
22031	Intrathecal or epidural injection (initial) of a therapeutic substance or substances, with or without insertion of a catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22036 applies (005) (basic units)	$264.50
22036	Intrathecal or epidural injection (subsequent) of a therapeutic substance or substances, using an in- situ catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22031 applies (003) (basic units)	$158.70
22040	Introduction of a regional or field nerve block peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral or sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (002) (basic units)	$105.80
22045	Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral and sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (003) (basic units)	$158.70
22050	Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery (002) (basic units)	$105.80
22051	Intra-operative transoesophageal echocardiography - monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (009) (basic units)	$476.10
22055	Perfusion of limb or organ using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in subgroup 21 applies (012) (basic units)	$634.80
22060	Whole body perfusion, cardiac bypass, using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in subgroup 21 applies (020) (basic units)	$1,058.00
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 (005) (basic units)	$264.50
22070	Cardioplegia, blood or crystalloid, administration by any route, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in subgroup 21 applies (010) (basic units)	$529.00
22075	Deep hypothermic circulatory arrest, with core temperature less than 22c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in subgroup 21 applies (015) (basic units)	$793.50

Administration of anaesthesia in connection with a dental service

22900	Initiation of management by a medical practitioner of anaesthesia for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (006) (basic units)	$317.40
22905	Initiation of management of anaesthesia for restorative dental work (006) (basic units)	$317.40

Anaesthesia/perfusion time units

23010	Anaesthesia, perfusion or assistance at anaesthesia (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 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) (001) (basic units)	$52.90
23021	16 minutes to 20 minutes (002) (basic units)	$105.80
23022	21 minutes to 25 minutes (002) (basic units)	$105.80
23023	26 minutes to 30 minutes (002) (basic units)	$105.80
23031	31 minutes to 35 minutes (003) (basic units)	$158.70
23032	36 minutes to 40 minutes (003) (basic units)	$158.70
23033	41 minutes to 45 minutes (003) (basic units)	$158.70
23041	46 minutes to 50 minutes (004) (basic units)	$211.60
23042	51 minutes to 55 minutes (004) (basic units)	$211.60
23043	56 minutes to 1:00 hour (004) (basic units)	$211.60
23051	1:01 hours to 1:05 hours (005) (basic units)	$264.50
23052	1:06 hours to 1:10 hours (005) (basic units)	$264.50
23053	1:11 hours to 1:15 hours (005) (basic units)	$264.50
23061	1:16 hours to 1:20 hours (006) (basic units)	$317.40
23062	1:21 hours to 1:25 hours (006) (basic units)	$317.40
23063	1:26 hours to 1:30 hours (006) (basic units)	$317.40
23071	1:31 hours to 1:35 hours (007) (basic units)	$370.30
23072	1:36 hours to 1:40 hours (007) (basic units)	$370.30
23073	1:41 hours to 1:45 hours (007) (basic units)	$370.30
23081	1:46 hours to 1:50 hours (008) (basic units)	$423.20
23082	1:51 hours to 1:55 hours (008) (basic units)	$423.20
23083	1:56 hours to 2:00 hours (008) (basic units)	$423.20
23091	2:01 hours to 2:10 hours (009) (basic units)	$476.10
23101	2:11 hours to 2:20 hours (010) (basic units)	$529.00
23111	2:21 hours to 2:30 hours (011) (basic units)	$581.90
23112	2:31 hours to 2:40 hours (012) (basic units)	$634.80
23113	2:41 hours to 2:50 hours (013) (basic units)	$687.70
23114	2:51 hours to 3:00 hours (014) (basic units)	$740.60
23115	3:01 hours to 3:10 hours (015) (basic units)	$793.50
23116	3:11 hours to 3:20 hours (016) (basic units)	$846.40
23117	3:21 hours to 3:30 hours (017) (basic units)	$899.30

23118	3:31 hours to 3:40 hours (018) (basic units)	$952.20
23119	3:41 hours to 3:50 hours (019) (basic units)	$1,005.10
23121	3:51 hours to 4:00 hours (020) (basic units)	$1,058.00
23170	4:01 hours to 4:10 hours (021) (basic units)	$1,110.90
23180	4:11 hours to 4:20 hours (022) (basic units)	$1,163.80
23190	4:21 hours to 4:30 hours (023) (basic units)	$1,216.70
23200	4:31 hours to 4:40 hours (024) (basic units)	$1,269.60
23210	4:41 hours to 4:50 hours (025) (basic units)	$1,322.50
23220	4:51 hours to 5:00 hours (026) (basic units)	$1,375.40
23230	5:01 hours to 5:10 hours (027) (basic units)	$1,428.30
23240	5:11 hours to 5:20 hours (028) (basic units)	$1,481.20
23250	5:21 hours to 5:30 hours (029) (basic units)	$1,534.10
23260	5:31 hours to 5:40 hours (030) (basic units)	$1,587.00
23270	5:41 hours to 5:50 hours (031) (basic units)	$1,639.90
23280	5:51 hours to 6:00 hours (032) (basic units)	$1,692.80
23290	6:01 hours to 6:10 hours (033) (basic units)	$1,745.70
23300	6:11 hours to 6:20 hours (034) (basic units)	$1,798.60
23310	6:21 hours to 6:30 hours (035) (basic units)	$1,851.50
23320	6:31 hours to 6:40 hours (036) (basic units)	$1,904.40
23330	6:41 hours to 6:50 hours (037) (basic units)	$1,957.30
23340	6:51 hours to 7:00 hours (038) (basic units)	$2,010.20
23350	7:01 hours to 7:10 hours (039) (basic units)	$2,063.10
23360	7:11 hours to 7:20 hours (040) (basic units)	$2,116.00
23370	7:21 hours to 7:30 hours (041) (basic units)	$2,168.90
23380	7:31 hours to 7:40 hours (042) (basic units)	$2,221.80
23390	7:41 hours to 7:50 hours (043) (basic units)	$2,274.70
23400	7:51 hours to 8:00 hours (044) (basic units)	$2,327.60
23410	8:01 hours to 8:10 hours (045) (basic units)	$2,380.50
23420	8:11 hours to 8:20 hours (046) (basic units)	$2,433.40
23430	8:21 hours to 8:30 hours (047) (basic units)	$2,486.30
23440	8:31 hours to 8:40 hours (048) (basic units)	$2,539.20
23450	8:41 hours to 8:50 hours (049) (basic units)	$2,592.10
23460	8:51 hours to 9:00 hours (050) (basic units)	$2,645.00
23470	9:01 hours to 9:10 hours (051) (basic units)	$2,697.90
23480	9:11 hours to 9:20 hours (052) (basic units)	$2,750.80
23490	9:21 hours to 9:30 hours (053) (basic units)	$2,803.70
23500	9:31 hours to 9:40 hours (054) (basic units)	$2,856.60
23510	9:41 hours to 9:50 hours (055) (basic units)	$2,909.50
23520	9:51 hours to 10:00 hours (056) (basic units)	$2,962.40

23530	10:01 hours to 10:10 hours (057) (basic units)	$3,015.30
23540	10:11 hours to 10:20 hours (058) (basic units)	$3,068.20
23550	10:21 hours to 10:30 hours (059) (basic units)	$3,121.10
23560	10:31 hours to 10:40 hours (060) (basic units)	$3,174.00
23570	10:41 hours to 10:50 hours (061) (basic units)	$3,226.90
23580	10:51 hours to 11:00 hours (062) (basic units)	$3,279.80
23590	11:01 hours to 11:10 hours (063) (basic units)	$3,332.70
23600	11:11 hours to 11:20 hours (064) (basic units)	$3,385.60
23610	11:21 hours to 11:30 hours (065) (basic units)	$3,438.50
23620	11:31 hours to 11:40 hours (066) (basic units)	$3,491.40
23630	11:41 hours to 11:50 hours (067) (basic units)	$3,544.30
23640	11:51 hours to 12:00 hours (068) (basic units)	$3,597.20
23650	12:01 hours to 12:10 hours (069) (basic units)	$3,650.10
23660	12:11 hours to 12:20 hours (070) (basic units)	$3,703.00
23670	12:21 hours to 12:30 hours (071) (basic units)	$3,755.90
23680	12:31 hours to 12:40 hours (072) (basic units)	$3,808.80
23690	12:41 hours to 12:50 hours (073) (basic units)	$3,861.70
23700	12:51 hours to 13:00 hours (074) (basic units)	$3,914.60
23710	13:01 hours to 13:10 hours (075) (basic units)	$3,967.50
23720	13:11 hours to 13:20 hours (076) (basic units)	$4,020.40
23730	13:21 hours to 13:30 hours (077) (basic units)	$4,073.30
23740	13:31 hours to 13:40 hours (078) (basic units)	$4,126.20
23750	13:41 hours to 13:50 hours (079) (basic units)	$4,179.10
23760	13:51 hours to 14:00 hours (080) (basic units)	$4,232.00
23770	14:01 hours to 14:10 hours (081) (basic units)	$4,284.90
23780	14:11 hours to 14:20 hours (082) (basic units)	$4,337.80
23790	14:21 hours to 14:30 hours (083) (basic units)	$4,390.70
23800	14:31 hours to 14:40 hours (084) (basic units)	$4,443.60
23810	14:41 hours to 14:50 hours (085) (basic units)	$4,496.50
23820	14:51 hours to 15:00 hours (086) (basic units)	$4,549.40
23830	15:01 hours to 15:10 hours (087) (basic units)	$4,602.30
23840	15:11 hours to 15:20 hours (088) (basic units)	$4,655.20
23850	15:21 hours to 15:30 hours (089) (basic units)	$4,708.10
23860	15:31 hours to 15:40 hours (090) (basic units)	$4,761.00
23870	15:41 hours to 15:50 hours (091) (basic units)	$4,813.90
23880	15:51 hours to 16:00 hours (092) (basic units)	$4,866.80
23890	16:01 hours to 16:10 hours (093) (basic units)	$4,919.70
23900	16:11 hours to 16:20 hours (094) (basic units)	$4,972.60
23910	16:21 hours to 16:30 hours (095) (basic units)	$5,025.50

23920	16:31 hours to 16:40 hours (096) (basic units)	$5,078.40
23930	16:41 hours to 16:50 hours (097) (basic units)	$5,131.30
23940	16:51 hours to 17:00 hours (098) (basic units)	$5,184.20
23950	17:01 hours to 17:10 hours (099) (basic units)	$5,237.10
23960	17:11 hours to 17:20 hours (100) (basic units)	$5,290.00
23970	17:21 hours to 17:30 hours (101) (basic units)	$5,342.90
23980	17:31 hours to 17:40 hours (102) (basic units)	$5,395.80
23990	17:41 hours to 17:50 hours (103) (basic units)	$5,448.70
24100	17:51 hours to 18:00 hours (104) (basic units)	$5,501.60
24101	18:01 hours to 18:10 hours (105) (basic units)	$5,554.50
24102	18:11 hours to 18:20 hours (106) (basic units)	$5,607.40
24103	18:21 hours to 18:30 hours (107) (basic units)	$5,660.30
24104	18:31 hours to 18:40 hours (108) (basic units)	$5,713.20
24105	18:41 hours to 18:50 hours (109) (basic units)	$5,766.10
24106	18:51 hours to 19:00 hours (110) (basic units)	$5,819.00
24107	19:01 hours to 19:10 hours (111) (basic units)	$5,871.90
24108	19:11 hours to 19:20 hours (112) (basic units)	$5,924.80
24109	19:21 hours to 19:30 hours (113) (basic units)	$5,977.70
24110	19:31 hours to 19:40 hours (114) (basic units)	$6,030.60
24111	19:41 hours to 19:50 hours (115) (basic units)	$6,083.50
24112	19:51 hours to 20:00 hours (116) (basic units)	$6,136.40
24113	20:01 hours to 20:10 hours (117) (basic units)	$6,189.30
24114	20:11 hours to 20:20 hours (118) (basic units)	$6,242.20
24115	20:21 hours to 20:30 hours (119) (basic units)	$6,295.10
24116	20:31 hours to 20:40 hours (120) (basic units)	$6,348.00
24117	20:41 hours to 20:50 hours (121) (basic units)	$6,400.90
24118	20:51 hours to 21:00 hours (122) (basic units)	$6,453.80
24119	21:01 hours to 21:10 hours (123) (basic units)	$6,506.70
24120	21:11 hours to 21:20 hours (124) (basic units)	$6,559.60
24121	21:21 hours to 21:30 hours (125) (basic units)	$6,612.50
24122	21:31 hours to 21:40 hours (126) (basic units)	$6,665.40
24123	21:41 hours to 21:50 hours (127) (basic units)	$6,718.30
24124	21:51 hours to 22:00 hours (128) (basic units)	$6,771.20
24125	22:01 hours to 22:10 hours (129) (basic units)	$6,824.10
24126	22:11 hours to 22:20 hours (130) (basic units)	$6,877.00
24127	22:21 hours to 22:30 hours (131) (basic units)	$6,929.90
24128	22:31 hours to 22:40 hours (132) (basic units)	$6,982.80
24129	22:41 hours to 22:50 hours (133) (basic units)	$7,035.70
24130	22:51 hours to 23:00 hours (134) (basic units)	$7,088.60

24131	23:01 hours to 23:10 hours (135) (basic units)	$7,141.50
24132	23:11 hours to 23:20 hours (136) (basic units)	$7,194.40
24133	23:21 hours to 23:30 hours (137) (basic units)	$7,247.30
24134	23:31 hours to 23:40 hours (138) (basic units)	$7,300.20
24135	23:41 hours to 23:50 hours (139) (basic units)	$7,353.10
24136	23:51 hours to 24:00 hours (140) (basic units)	$7,406.00

Anaesthesia/perfusion modifying units - physical status

25000	Anaesthesia, perfusion or assistance at anaesthesia (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 - where the patient has severe systemic disease equivalent to asa physical status indicator 3 (001) (basic units)	$52.90
25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to asa physical status indicator 4 (002) (basic units)	$105.80
25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to asa physical status indicator 5 (003) (basic units)	$158.70

Anaesthesia/perfusion modifying units - other

25015	Anaesthesia, perfusion or assistance at anaesthesia - where the patient is less than 12 months of age or 70 years or greater (001) (basic units)	$52.90
25020	Anaesthesia, perfusion or assistance at anaesthesia - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (002) (basic units)	$105.80

Anaesthesia after hours emergency modifier

25025	Emergency anaesthesia performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies (000) (basic units) Derived fee: An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050	DF
25030	Assistance at after hours emergency anaesthesia where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies (000) (basic units) Derived fee: An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item in the range 25200 - 25205 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050	DF

Perfusion after hours emergency modifier

25050	After hours emergency perfusion where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies (000) (basic units) Derived fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050 and 22065 - 22075	DF

Assistance at anaesthesia

25200	Assistance in the administration of anaesthesia requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (005) (basic units) Derived fee: An amount of $264.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable, an item in the range 25000 - 25020	DF
25205	Assistance in the administration of elective anaesthesia, where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v)where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (005) (basic units) Derived fee: An amount of $264.50 (5 basic units), plus an item in the range 23010 - 24136, plus, where applicable, an item in the range 25000 - 25020.	DF

GROUP T8 - SURGICAL OPERATIONS

General

30001	Operative procedure, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds Derived fee: 50% of the fee which would have applied had the procedure not been discontinued.	DF
30003	Localised burns, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$49.60
30006	Extensive burns, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$73.70
30009	Localised burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$96.20
30010	Localised burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$136.10
30013	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$270.90
30014	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$285.50
30017	Burns, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Assist.) (Anaes.)	$515.90
30020	Burns, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Assist.) (Anaes.)	$1,168.80

30023	Wound of soft tissue, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.) (Anaes.)	$588.70
30024	Wound of soft tissue, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.) (Anaes.)	$561.20
30026	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$82.70
30029	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm in length), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$142.30
30032	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), superficial (Anaes.)	$130.50
30035	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), involving deeper tissue (Anaes.)	$186.10
30038	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$142.30
30041	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$227.90
30042	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$335.10
30045	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), superficial (Anaes.)	$186.10
30048	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	$236.90
30049	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	$342.20
30052	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Assist.) (Anaes.)	$421.80
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.)	$135.00
30058	Postoperative haemorrhage, control of, under general anaesthesia, as an independent procedure (Anaes.)	$262.00
30061	Superficial foreign body, removal of, (including from cornea or sclera) as an independent procedure (Anaes.)	$38.30
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.)	$95.70

30064	Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	$174.00
30067	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Assist.) (Anaes.)	$354.00
30068	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Assist.) (Anaes.)	$507.00
30071	Diagnostic biopsy of skin or mucous membrane, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	$98.30
30074	Diagnostic biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	$199.80
30075	Diagnostic biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	$279.30
30078	Diagnostic drill biopsy of lymph gland, deep tissue or organ, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	$81.70
30081	Diagnostic biopsy of bone marrow by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)	$174.80
30084	Diagnostic biopsy of bone marrow by trephine using percutaneous approach with a Jamshidi needle or similar device, where the biopsy is sent for pathological examination (Anaes.)	$101.00
30087	Diagnostic biopsy of bone marrow by aspiration or punch biopsy of synovial membrane, where the biopsy is sent for pathological examination (Anaes.)	$50.70
30090	Diagnostic biopsy of pleura, percutaneous 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.)	$220.60
30093	Diagnostic needle biopsy of vertebra, where the biopsy is sent for pathological examination (Anaes.)	$269.60
30094	Diagnostic percutaneous aspiration biopsy of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.)	$331.90
30096	Diagnostic scalene node biopsy, by open procedure, where the specimen excised is sent for pathological examination (Anaes.)	$290.90
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.	$182.70
30099	Sinus, excision of, involving superficial tissue only (Anaes.)	$152.00
30102	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$251.50
30103	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$334.50
30104	Pre-auricular sinus, excision of (Anaes.)	$245.20
30106	Ganglion or small bursa, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$257.40
30107	Ganglion or small bursa, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$397.60
30110	Bursa (large), including olecranon, calcaneum or patella, excision of (Assist.) (Anaes.)	$546.00
30111	Bursa (large), including olecranon, calcaneum or patella, excision of (Assist.) (Anaes.)	$684.70
30114	Bursa, semimembranosus (Baker's cyst), excision of (Assist.) (Anaes.)	$700.70
30165	Lipectomy transverse wedge excision of abdominal apron, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a	$930.00

	service to which item 45564, 45565 or 45530 applies (Assist.) (Anaes.)	
30168	Lipectomy wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 1 excision (Assist.) (Anaes.)	$907.30
30171	Lipectomy wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 2 or more excisions (Assist.) (Anaes.)	$1,395.00
30174	Lipectomy subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall, not being a service associated with items 45564 or 45565 or 45530 (Assist.) (Anaes.)	$1,395.00
30177	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 performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Assist.) (Anaes.)	$2,090.00
30180	Axillary hyperhidrosis, partial excision for (Anaes.)	$280.00
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (Anaes.)	$558.20
30185	Palmar or plantar warts (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies (Anaes.)	$288.80
30186	Palmar or plantar warts (less than 10), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies (Anaes.)	$75.10
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.)	$341.80
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 (Anaes.)	$290.00
30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision- ablation including associated resurfacing (10 or more tumours) (Assist.) (Anaes.)	$724.80
30192	Premalignant skin lesions (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)	$63.00
30195	Benign neoplasm of skin, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.)	$101.00
30196	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.)	$199.00
30197	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 or more lesions) (Anaes.)	$700.40
30202	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles, not being a service to which item 30203 applies	$75.90
30203	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles (10 or more lesions)	$270.80

30205	Malignant neoplasm of skin proven by histopathology, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles where the malignant neoplasm extends into cartilage (Anaes.)	$199.00
30207	Skin lesions, multiple injections with hydrocortisone or similar preparations (Anaes.)	$79.90
30210	Keloid and other skin lesions, extensive, multiple injections of hydrocortisone or similar preparations where undertaken in the operating theatre of a hospital (Anaes.)	$285.70
30213	Telangiectases or starburst vessels on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.)	$223.50
30214	Telangiectases or starburst vessels on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration - where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period	$173.80
30216	Haematoma, aspiration of (Anaes.)	$42.20
30219	Haematoma, furuncle, small abscess or similar lesion not requiring admission to a hospital - incision with drainage of (excluding aftercare)	$42.20
30223	Large haematoma, large abscess, carbuncle, cellulitis or similar lesion, requiring admission to a hospital, incision with drainage of (excluding aftercare) (Anaes.)	$286.10
30224	Percutaneous drainage of deep abscess using interventional imaging techniques - but not including imaging (Anaes.)	$410.40
30225	Abscess drainage tube, exchange of using interventional imaging techniques - but not including imaging (Anaes.)	$491.10
30226	Muscle, excision of (limited) or fasciotomy (Anaes.)	$276.50
30229	Muscle, excision of (extensive) (Assist.) (Anaes.)	$498.40
30232	Muscle, ruptured, repair of (limited), not associated with external wound (Anaes.)	$409.60
30235	Muscle, ruptured, repair of (extensive), not associated with external wound (Assist.) (Anaes.)	$544.40
30238	Fascia, deep, repair of, for herniated muscle (Anaes.)	$276.40
30241	Bone tumour, innocent, excision of, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$644.40
30244	Styloid process of temporal bone, removal of (Assist.) (Anaes.)	$730.00
30246	Parotid duct, repair of, using micro- surgical techniques (Assist.) (Anaes.)	$1,269.90
30247	Parotid gland, total extirpation of (Assist.) (Anaes.)	$1,242.10
30250	Parotid gland, total extirpation of with preservation of facial nerve (Assist.) (Anaes.)	$2,562.20
30251	Recurrent parotid tumour, excision of, with preservation of facial nerve (Assist.) (Anaes.)	$3,690.30
30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve (Assist.) (Anaes.)	$1,784.60
30255	Submandibular ducts, relocation of, for surgical control of drooling (Assist.) (Anaes.)	$2,495.00
30256	Submandibular gland, extirpation of (Assist.) (Anaes.)	$808.20
30259	Sublingual gland, extirpation of (Anaes.)	$412.50
30262	Salivary gland, dilatation or diathermy of duct (Anaes.)	$113.20
30265	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$185.10

30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$279.20
30269	Salivary gland, repair of cutaneous fistula of (Anaes.)	$345.00
30272	Tongue, partial excision of (Assist.) (Anaes.)	$535.20
30275	Radical excision of intraoral tumour involving resection of mandible and lymph glands of neck (commandotype operation) (Assist.) (Anaes.)	$3,188.90
30278	Tongue tie, repair of, not being a service to which another item in this Group applies (Anaes.)	$77.50
30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.)	$265.00
30282	Ranula or mucous cyst of mouth, removal of (Anaes.)	$244.70
30283	Ranula or mucous cyst of mouth, removal of (Anaes.)	$332.60
30286	Branchial cyst, removal of (Assist.) (Anaes.)	$851.80
30289	Branchial fistula, removal of (Assist.) (Anaes.)	$1,011.00
30293	Cervical oesophagostomy; or closure of cervical oesophagostomy with or without plastic repair (Assist.) (Anaes.)	$816.20
30294	Cervical oesophagectomy with tracheostomy and oesophagostomy, with or without plastic reconstruction; or laryngopharyngectomy with tracheostomy and plastic reconstruction (Assist.) (Anaes.)	$2,775.40
30296	Thyroidectomy, total (Assist.) (Anaes.)	$2,101.60
30297	Thyroidectomy following previous thyroid surgery (Assist.) (Anaes.)	$1,855.20
30299	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level I axilla (as defined at t8.16), using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Assist.) (Anaes.)	$1,173.30
30300	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level ii/iii axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Assist.) (Anaes.)	$1,401.30
30302	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level i axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Assist.) (Anaes.)	$930.30
30303	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level ii/iii axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Assist.) (Anaes.)	$1,025.50
30306	Total hemithyroidectomy (Assist.) (Anaes.)	$1,575.70
30308	Bilateral subtotal thyroidectomy (Assist.) (Anaes.)	$1,800.00
30309	Thyroidectomy, subtotal for thyrotoxicosis (Assist.) (Anaes.)	$2,175.80
30310	Thyroid, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Assist.) (Anaes.)	$865.10
30313	Thyroglossal cyst, removal of (Assist.) (Anaes.)	$669.40
30314	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Assist.) (Anaes.)	$1,054.50
30315	Parathyroid operation for hyperparathyroidism (Assist.) (Anaes.)	$2,210.80
30317	Cervical reexploration for recurrent or persistent hyperparathyroidism (Assist.) (Anaes.)	$2,487.80

30318	Mediastinum, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Assist.) (Anaes.)	$1,659.70
30320	Mediastinum, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Assist.) (Anaes.)	$2,487.80
30321	Retroperitoneal neuroendocrine tumour, removal of (Assist.) (Anaes.)	$1,652.80
30323	Retroperitoneal neuroendocrine tumour, removal of, requiring complex and extensive dissection (Assist.) (Anaes.)	$2,487.80
30324	Adrenal gland tumour, excision of (Assist.) (Anaes.)	$2,583.50
30329	Lymph glands of groin, limited excision of (Anaes.)	$448.70
30330	Lymph glands of groin, radical excision of (Assist.) (Anaes.)	$1,318.00
30332	Lymph nodes of axilla, limited excision of (sampling) (Assist.) (Anaes.)	$615.70
30335	Lymph nodes of axilla, complete excision of, to level I (Assist.) (Anaes.)	$1,435.70
30336	Lymph nodes of axilla, complete excision of, to level II or level III (Assist.) (Anaes.)	$1,888.50
30373	Laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Assist.) (Anaes.)	$886.50
30375	Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, reduction of intussusception, removal of Meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty (adult) or drainage of pancreas (Assist.) (Anaes.)	$953.90
30376	Laparotomy involving division of peritoneal adhesions (where no other intraabdominal procedure is performed) (Assist.) (Anaes.)	$953.90
30378	Laparotomy involving division of adhesions in association with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours (Assist.) (Anaes.)	$953.90
30379	Laparotomy with division of extensive adhesions (duration greater than 2 hours) with or without insertion of long intestinal tube (Assist.) (Anaes.)	$1,690.00
30382	Enterocutaneous fistula, radical repair of, involving extensive dissection and resection of bowel (Assist.) (Anaes.)	$2,383.30
30384	Laparotomy for grading of lymphoma, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Assist.) (Anaes.)	$2,025.10
30385	Laparotomy for control of postoperative haemorrhage, where no other procedure is performed (Assist.) (Anaes.)	$1,035.60
30387	Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies (Assist.) (Anaes.)	$1,275.10
30388	Laparotomy for trauma involving 3 or more organs (Assist.) (Anaes.)	$2,911.80
30390	Laparoscopy, diagnostic, not being a service associated with any other laparoscopic procedure (Anaes.)	$414.00
30391	Laparoscopy, with biopsy (Assist.) (Anaes.)	$557.60
30392	Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Assist.) (Anaes.)	$1,084.70
30393	Laparoscopic division of adhesions in association with another intra- abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Assist.) (Anaes.)	$968.40
30394	Laparotomy for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Assist.) (Anaes.)	$908.10

30396	Laparotomy for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision with or without closure of abdomen and with or without mesh or zipper insertion (Assist.) (Anaes.)	$1,854.80
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.)	$423.90
30399	Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Assist.) (Anaes.)	$581.50
30400	Laparotomy with insertion of portacath for administration of cytotoxic therapy including placement of reservoir (Assist.) (Anaes.)	$1,154.40
30402	Retroperitoneal abscess, drainage of, not involving laparotomy (Assist.) (Anaes.)	$849.20
30403	Ventral, incisional, or recurrent hernia or burst abdomen, repair of with or without mesh (Assist.) (Anaes.)	$960.80
30405	Ventral or incisional hernia, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Assist.) (Anaes.)	$1,668.60
30406	Paracentesis abdominis (Anaes.)	$95.80
30408	Peritoneovenous shunt, insertion of (Assist.) (Anaes.)	$714.70
30409	Liver biopsy, percutaneous (Anaes.)	$324.40
30411	Liver biopsy by wedge excision when performed in association with another intraabdominal procedure (Anaes.)	$200.00
30412	Liver biopsy by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.)	$95.20
30414	Liver, subsegmental resection of, (local excision), other than for trauma (Assist.) (Anaes.)	$1,258.80
30415	Liver, segmental resection of, other than for trauma (Assist.) (Anaes.)	$2,509.40
30416	Liver cyst, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Assist.) (Anaes.)	$1,363.70
30417	Liver cysts, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Assist.) (Anaes.)	$2,045.20
30418	Liver, lobectomy of, other than for trauma (Assist.) (Anaes.)	$2,911.80
30419	Liver tumours, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 apply (Assist.) (Anaes.)	$1,451.30
30421	Liver, tri-segmental resection (extended lobectomy) of, other than for trauma (Assist.) (Anaes.)	$3,634.90
30422	Liver, repair of superficial laceration of, for trauma (Assist.) (Anaes.)	$1,228.80
30425	Liver, repair of deep multiple lacerations of, or debridement of, for trauma (Assist.) (Anaes.)	$2,383.30
30427	Liver, segmental resection of, for trauma (Assist.) (Anaes.)	$2,470.20
30428	Liver, lobectomy of, for trauma (Assist.) (Anaes.)	$2,642.90
30430	Liver, extended lobectomy (tri- segmental resection) of, for trauma (Assist.) (Anaes.)	$4,230.80
30431	Liver abscess, open abdominal drainage of (Assist.) (Anaes.)	$960.80
30433	Liver abscess (multiple), open abdominal drainage of (Assist.) (Anaes.)	$1,318.60
30434	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Assist.) (Anaes.)	$1,072.70

30436	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Assist.) (Anaes.)	$1,034.00
30437	Hydatid cyst of liver, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Assist.) (Anaes.)	$1,366.10
30438	Hydatid cyst of liver, excision of, with drainage and excision of liver tissue (Assist.) (Anaes.)	$2,098.30
30439	Operative cholangiography or operative pancreatography or intra operative ultrasound of the biliary tract (including 1 or more examinations performed during the 1 operation) (Assist.) (Anaes.)	$338.90
30440	Cholangiogram, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Assist.) (Anaes.)	$924.50
30441	Intra operative ultrasound for staging of intra abdominal tumours (Anaes.)	$251.50
30442	Choledochoscopy in conjunction with another procedure (Anaes.)	$335.10
30443	Cholecystectomy (Assist.) (Anaes.)	$1,347.80
30445	Laparoscopic cholecystectomy (Assist.) (Anaes.)	$1,381.40
30446	Laparoscopic cholecystectomy when procedure is completed by laparotomy (Assist.) (Anaes.)	$1,374.80
30448	Laparoscopic cholecystectomy, involving removal of common duct calculi via the cystic duct (Assist.) (Anaes.)	$1,773.10
30449	Laparoscopic cholecystectomy with removal of common duct calculi via laparoscopic choledochotomy (Assist.) (Anaes.)	$1,973.60
30450	Calculus of biliary or renal tract, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Assist.) (Anaes.)	$955.30
30451	Biliary drainage tube, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Assist.) (Anaes.)	$447.20
30452	Choledochoscopy with balloon dilatation of a stricture or passage of stent or extraction of calculi (Assist.) (Anaes.)	$684.60
30454	Choledochotomy (with or without cholecystectomy), with or without removal of calculi (Assist.) (Anaes.)	$1,560.80
30455	Choledochotomy (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Assist.) (Anaes.)	$1,869.00
30457	Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (Assist.) (Anaes.)	$2,537.60
30458	Transduodenal operation on sphincter of Oddi, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Assist.) (Anaes.)	$1,866.70
30460	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Assist.) (Anaes.)	$1,571.30
30461	Radical resection of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Assist.) (Anaes.)	$2,679.80
30463	Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Assist.) (Anaes.)	$3,641.60

30464	Radical resection of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Assist.) (Anaes.)	$3,970.30
30466	Intrahepatic biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Assist.) (Anaes.)	$2,285.90
30467	Intraheptic bypass of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Assist.) (Anaes.)	$2,757.80
30469	Biliary stricture, repair of, after 1 or more operations on the biliary tree (Assist.) (Anaes.)	$3,135.10
30472	Hepatic or common bile duct, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Assist.) (Anaes.)	$1,637.40
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 30476 or 30478 applies (Anaes.)	$334.10
30475	Endoscopy with balloon dilatation of gastric or gastroduodenal stricture (Anaes.)	$590.30
30476	Oesophagoscopy (not being a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.)	$452.50
30478	Oesophagoscopy (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.)	$472.70
30479	Endoscopy with laser therapy or argon plasma coagulation, for the treatment of neoplasia, benign vascular lesions, strictures of the gastrointestinal tract, tumorous overgrowth through or over oesophageal stents, peptic ulcers, angiodysplasia, gastric antral vascular ectasia (gave) or post-polypectomy bleeding, 1 or more of (Anaes.)	$879.40
30481	Percutaneous gastrostomy (initial procedure), including any associated imaging services (Anaes.)	$647.40
30482	Percutaneous gastrostomy (repeat procedure), including any associated imaging services (Anaes.)	$461.30
30483	Gastrostomy button, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.)	$320.90
30484	Endoscopic retrograde cholangiopancreatography (Anaes.)	$663.10
30485	Endoscopic sphincterotomy with or without extraction of stones from common bile duct (Anaes.)	$1,035.60
30487	Small bowel intubation with biopsy, as an independant procedure (Anaes.)	$328.00
30488	Small bowel intubation as an independent procedure (Anaes.)	$163.20
30490	Oesophageal prosthesis, insertion of, including endoscopy and dilatation (Anaes.)	$953.90
30491	Bile duct, endoscopic stenting of (including endoscopy and dilatation) (Anaes.)	$1,005.50
30492	Bile duct, percutaneous stenting of (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.)	$1,328.80
30493	Biliary manometry (Anaes.)	$610.20
30494	Endoscopic biliary dilatation (Anaes.)	$767.70
30495	Percutaneous biliary dilatation for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.)	$1,328.80

30496	Vagotomy, truncal or selective, with or without pyloroplasty or gastroenterostomy (Assist.) (Anaes.)	$930.80
30497	Vagotomy and antrectomy (Assist.) (Anaes.)	$1,109.80
30499	Vagotomy, highly selective (Assist.) (Anaes.)	$1,521.90
30500	Vagotomy, highly selective with duodenoplasty for peptic stricture (Assist.) (Anaes.)	$1,624.10
30502	Vagotomy, highly selective, with dilatation of pylorus (Assist.) (Anaes.)	$1,559.90
30503	Vagotomy or antrectomy, or both, for peptic ulcer following previous operation for peptic ulcer (Assist.) (Anaes.)	$1,746.70
30505	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision (Assist.) (Anaes.)	$1,095.50
30506	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Assist.) (Anaes.)	$1,528.30
30508	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Assist.) (Anaes.)	$1,854.80
30509	Bleeding peptic ulcer, control of, involving gastric resection (other than wedge resection) (Assist.) (Anaes.)	$1,854.80
30511	Morbid obesity, gastric reduction or gastroplasty for, by any method (Assist.) (Anaes.)	$1,980.00
30512	Morbid obesity, gastric bypass for, by any method including anastomosis (Assist.) (Anaes.)	$2,620.30
30514	Morbid obesity, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Assist.) (Anaes.)	$2,800.10
30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy (Assist.) (Anaes.)	$1,296.80
30517	Gastroenterostomy, pyloroplasty or gastroduodenostomy, reconstruction of (Assist.) (Anaes.)	$1,627.30
30518	Partial gastrectomy (Assist.) (Anaes.)	$2,240.00
30520	Gastric tumour, removal of, by local excision, not being a service to which item 30518 applies (Assist.) (Anaes.)	$1,228.80
30521	Gastrectomy, total, for benign disease (Assist.) (Anaes.)	$2,278.70
30523	Gastrectomy, subtotal radical, for carcinoma, (including splenectomy when performed) (Assist.) (Anaes.)	$2,485.90
30524	Gastrectomy, total radical, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Assist.) (Anaes.)	$3,003.90
30526	Gastrectomy, total, and including lower oesophagus, performed by left thoraco- abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Assist.) (Anaes.)	$3,924.30
30527	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Assist.) (Anaes.)	$1,679.80
30529	Antireflux operation by fundoplasty, with oesophagoplasty for stricture or short oesophagus (Assist.) (Anaes.)	$2,383.30
30530	Antireflux operation by cardiopexy, with or without fundoplasty (Assist.) (Anaes.)	$1,427.10
30532	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus by laparoscopy or open operation (Assist.) (Anaes.)	$1,661.40
30533	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with fundoplasty, with or without closure of the diaphragmatic hiatus by laparoscopy or open	$1,966.40

	operation (Assist.) (Anaes.)	
30535	Oesophagectomy with gastric reconstruction by abdominal mobilisation and thoracotomy (Assist.) (Anaes.)	$3,097.80
30536	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Assist.) (Anaes.)	$3,135.10
30538	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.)	$2,174.10
30539	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.)	$1,593.90
30541	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Assist.) (Anaes.)	$2,762.70
30542	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.)	$1,876.30
30544	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.)	$1,617.60
30545	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Assist.) (Anaes.)	$3,344.30
30547	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.)	$1,999.40
30548	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.)	$1,720.10
30550	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Assist.) (Anaes.)	$3,753.90
30551	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.)	$2,592.40
30553	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.)	$1,665.90
30554	Oesophagectomy with reconstruction by free jejunal graft - 1 surgeon (Assist.) (Anaes.)	$3,630.90
30556	Oesophagectomy with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.)	$2,559.50
30557	Oesophagectomy with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.)	$1,849.80
30559	Oesophagus, local excision for tumour of (Assist.) (Anaes.)	$1,549.60
30560	Oesophageal perforation, repair of, by thoracotomy (Assist.) (Anaes.)	$1,720.10
30562	Enterostomy or colostomy, closure of not involving resection of bowel (Assist.) (Anaes.)	$1,087.00
30563	Colostomy or ileostomy, refashioning of (Assist.) (Anaes.)	$1,087.00
30564	Small bowel strictureplasty for chronic inflammatory bowel disease (Assist.) (Anaes.)	$1,425.10
30565	Small intestine, resection of, without anastomosis (including formation of stoma) (Assist.) (Anaes.)	$1,587.00
30566	Small intestine, resection of, with anastomosis (Assist.) (Anaes.)	$1,757.30

30568	Intraoperative enterotomy for visualisation of the small intestine by endoscopy (Assist.) (Anaes.)	$1,326.30
30569	Endoscopic examination of small bowel with flexible endoscope passed at laparotomy, with or without biopsies (Assist.) (Anaes.)	$677.30
30571	Appendicectomy, not being a service to which item 30574 applies (Assist.) (Anaes.)	$804.90
30572	Laparoscopic appendicectomy (Assist.) (Anaes.)	$806.40
30574	Appendicectomy, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)	$264.20
30575	Pancreatic abscess, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Assist.) (Anaes.)	$946.70
30577	Pancreatic necrosectomy for pancreatic necrosis or abscess formation requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Assist.) (Anaes.)	$1,980.60
30578	Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Assist.) (Anaes.)	$2,092.40
30580	Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Assist.) (Anaes.)	$1,906.50
30581	Endocrine tumour, exploration of pancreas or duodenum for, but no tumour found (Assist.) (Anaes.)	$1,206.50
30583	Distal pancreatectomy (Assist.) (Anaes.)	$2,167.00
30584	Pancreatico-duodenectomy, Whipple's operation, with or without preservation of pylorus (Assist.) (Anaes.)	$3,216.90
30586	Pancreatic cyst anastomosis to stomach or duodenum - by open or endoscopic means (Assist.) (Anaes.)	$1,280.50
30587	Pancreatic cyst, anastomosis to Roux loop of jejunum (Assist.) (Anaes.)	$1,326.30
30589	Pancreatico-jejunostomy for pancreatitis or trauma (Assist.) (Anaes.)	$2,278.70
30590	Pancreatico-jejunostomy following previous pancreatic surgery (Assist.) (Anaes.)	$2,509.40
30593	Pancreatectomy, near total or total (including duodenum), with or without splenectomy (Assist.) (Anaes.)	$3,440.20
30594	Pancreatectomy for pancreatitis following previously attempted drainage procedure or partial resection (Assist.) (Anaes.)	$3,970.30
30596	Splenorrhaphy or partial splenectomy (Assist.) (Anaes.)	$1,638.50
30597	Splenectomy (Assist.) (Anaes.)	$1,310.50
30599	Splenectomy, for massive spleen (weighing more than 1500gms) or involving thoraco-abdominal incision (Assist.) (Anaes.)	$2,383.30
30600	Diaphragmatic hernia, traumatic, repair of (Assist.) (Anaes.)	$1,429.20
30601	Diaphragmatic hernia, congenital, repair of, by thoracic or abdominal approach) (Assist.) (Anaes.)	$1,803.10
30602	Portal hypertension, porto-caval shunt for (Assist.) (Anaes.)	$2,719.10
30603	Portal hypertension, meso-caval shunt for (Assist.) (Anaes.)	$2,597.00
30605	Portal hypertension, selective spleno- renal shunt for (Assist.) (Anaes.)	$3,396.00
30606	Portal hypertension, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Assist.) (Anaes.)	$2,025.10
30609	Femoral or inguinal hernia, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Assist.) (Anaes.)	$875.50

30612	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies (Assist.) (Anaes.)	$718.60
30614	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies (Assist.) (Anaes.)	$822.20
30615	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection (Assist.) (Anaes.)	$960.80
30616	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age (Anaes.)	$417.70
30617	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age (Anaes.)	$561.10
30620	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over (Assist.) (Anaes.)	$719.70
30621	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over (Assist.) (Anaes.)	$752.60
30628	Hydrocele, tapping of	$58.60
30631	Hydrocele, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.)	$464.10
30634	Varicocele, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Assist.) (Anaes.)	$422.60
30635	Varicocele, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Assist.) (Anaes.)	$605.10
30638	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (Assist.) (Anaes.)	$578.70
30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (Assist.) (Anaes.)	$737.80
30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Assist.) (Anaes.)	$997.30
30653	Circumcision of a male under 6 months of age (Anaes.)	$73.20
30656	Circumcision of a male under 10 years of age but not less than 6 months of age (Anaes.)	$170.20
30659	Circumcision of a male 10 years of age or over (Anaes.)	$425.00
30660	Circumcision of a male 10 years of age or over (Anaes.)	$425.00
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia (Anaes.)	$227.20
30666	Paraphimosis, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.)	$85.20
30672	Coccyx, excision of (Assist.) (Anaes.)	$803.20
30675	Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (Anaes.)	$473.90
30676	Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (Anaes.)	$700.40
30679	Pilonidal sinus, injection of sclerosant fluid under anaesthesia (Anaes.)	$163.30
30680	Double 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:have recurrent or persistent bleeding; andbe anaemic or have active bleeding; and have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)	$1,865.50

30682	Double 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: have recurrent or persistent bleeding; and be anaemic or have active bleeding; and have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)	$1,865.50
30684	Double 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 or laser 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: have recurrent or persistent bleeding; and be anaemic or have active bleeding; and have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)	$2,295.80
30686	Double 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 or laser 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: have recurrent or persistent bleeding; and be anaemic or have active bleeding; and have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)	$2,295.80
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.)	$730.60
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$581.80
30690	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$898.20
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 and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$581.80
30694	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$898.20
30696	Endoscopic ultrasound guided fine needle aspiration biopsy(s) (endoscopy with ultrasound imaging) to obtain one or more specimens from either: (a) mediastinal mass(es) or(b) locoregional nodes to stage non-small cell lung carcinomanot being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.)	$871.10
30710	Endobronchial ultrasound guided biopsy(s) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either:(a) transbronchial biopsy(s) of peripheral lung lesions; or(b) fine needle aspiration(s) of a mediastinal mass(es); or (c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinomanot being a service associated with another item in this subgroup or to which items 30696, 41892, 41898, and 60500 to 60509 applies (Anaes.)	$871.10

31000	Micrographically controlled serial excision of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.)	$1,018.00
31001	Micrographically controlled serial excision of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.)	$1,240.30
31002	Micrographically controlled serial excision of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.)	$1,473.70
31200	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach to an operation), removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies	$57.30
31205	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), lesion size up to and including 10mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335, where the specimen excised is sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$154.50
31210	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), lesion size more than 10mm and up to and including 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335, where the specimen excised is sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$224.70
31215	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335, where the specimen excised is sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$259.60
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), lesion size up to and including 10mm in diameter, removal of 4 to 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 - where the specimens excised are sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$347.90
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), lesion size up to and including 10mm in diameter, removal of more than 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 - where the specimens excised are sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$621.50
31230	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia, including excision to establish the diagnosis of tumours covered by items	$304.40

	31300 to 31335 - where the specimen excised is sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	
31235	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), including excision to establish the diagnosis of tumours covered by items 31300 to 31335, lesion size up to and including 10mm in diameter - where the specimen excised is sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$259.60
31240	Tumour (other than viral verrucae [common warts] and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), including excision to establish the diagnosis of tumours covered by items 31300 to 31335, lesion size more than 10mm in diameter - where the specimen excised is sent for histological examination (not being a service to which item 30195 applies) (Anaes.)	$304.40
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.)	$665.90
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.)	$624.30
31255	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter - where removal is by therapeutic surgical excision (other than by shave excision) and suture and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$399.50
31256	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, where previous excision was performed by the same practitioner, where the original tumour size was up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$386.30
31257	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$399.50
31258	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from nose, eyelid, lip, ear, digit or genitalia, whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.)	$399.50
31260	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter - where removal is by therapeutic surgical excision (other than shave excision) and suture and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$581.00
31261	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, where previous excision was performed by the same practitioner, where the original tumour size was more than 10mm in diameter and where removal is by	$581.00

	surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	
31262	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was more than 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$581.00
31263	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from nose, eyelid, lip, ear, digit or genitalia, whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is more than 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.)	$581.00
31265	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to and including 10mm in diameter and where removal is by therapeutic surgical excision (other than by shave excision) and suture, where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$340.10
31266	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), where previous excision was performed by the same practitioner, where the original tumour size was up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$303.90
31267	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$340.10
31268	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.)	$340.10
31270	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter and where removal is by therapeutic surgical excision (other than by shave excision) and suture, where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$469.00
31271	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), where previous excision was performed by the same practitioner, where the original tumour size was more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$434.20

31272	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$477.40
31273	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.)	$477.40
31275	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter and where removal is by therapeutic surgical excision (other than by shave excision) and suture, where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$539.50
31276	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), where previous excision was performed by the same practitioner, where the original tumour size was more than 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$552.50
31277	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was more than 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$539.50
31278	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is more than 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained - not being a service to which item 31295 applies (Anaes.)	$541.40
31280	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from areas of the body not covered by items 31255 and 31265, tumour size up to and including 10mm in diameter and where removal is by therapeutic surgical excision (other than by shave excision) and suture, where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$281.10
31281	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from areas of the body not covered by items 31255 and 31265, where previous excision was performed by the same practitioner, where the original tumour size was up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$247.50
31282	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from areas of the body not covered by items 31255 and 31265, performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was up to and including 10mm in diameter and where removal is by surgical excision (other than by	$287.00

	shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	
31283	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from areas of the body not covered by items 31255 and 31265, whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is up to and including 10mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$288.70
31285	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from areas of the body not covered by items 31260 and 31270, tumour size more than 10mm and up to and including 20mm in diameter and where removal is by therapeutic surgical excision (other than by shave excision) and suture, where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$375.60
31286	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from areas of the body not covered by items 31260 and 31270, where previous excision was performed by the same practitioner, where the original tumour size was more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$337.10
31287	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from areas of the body not covered by items 31260 and 31270, performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$392.00
31288	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from areas of the body not covered by items 31260 and 31270, whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is more than 10mm and up to and including 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$391.90
31290	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from areas of the body not covered by items 31260 and 31275, tumour size more than 20mm in diameter and where removal is by therapeutic surgical excision (other than by shave excision) and suture, where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination (Anaes.)	$444.40
31291	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from areas of the body not covered by items 31260 and 31275, where previous excision was performed by the same practitioner, where the original tumour size was more than 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$397.10
31292	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from areas of the body not covered by items 31260 and 31275, performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was more than 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination (Anaes.)	$444.40
31293	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from areas of the body not covered by items 31260 and 31275, whether previous excision was performed by the same practitioner or performed by a practitioner other than the practitioner who	$444.40

	provided the previous treatment, where the tumour size is more than 20mm in diameter and where removal is by surgical excision (other than by shave excision) and suture and where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	
31295	Basal cell carcinoma or squamous cell carcinoma, recurrent (where lesion was treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment, removal from the head or neck (anterior to the sternomastoid muscles), where removal is by surgical excision and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$529.90
31300	malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$577.50
31305	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle and removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$710.60
31310	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to and including 10mm in diameter (as defined above in the explanatory notes to this category) where removal is by definitive surgical excision and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$501.50
31315	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to and including 20mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$634.70
31320	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$710.60
31325	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from areas of the body not covered by items 31300 and 31310 - tumour size up to and including 10mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$487.90
31330	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from areas of the body not covered by items 31305 and 31310 - tumour size more than 10mm and up to and including 20mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$577.50

31335	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or hutchinson's melanotic freckle - removal from areas of the body not covered by items 31305 and 31320 - tumour size more than 20mm in diameter and where removal is by definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	$665.90
31340	Note: Multiple Operation and Multiple Anaesthetic rules apply to this item. muscle, bone or cartilage, excision of one or more of, where clinically indicated, where the specimen excised is sent for histological confirmation, performed in association with excision of malignant tumour of skin covered by item 31255, 31256, 31257, 31258, 31260, 31261, 31262, 31263, 31265, 31266, 31267, 31268, 31270, 31271, 31272, 31273, 31275, 31276, 31277, 31278, 31280, 31281, 31282, 31283, 31285, 31286, 31287, 31288, 31290, 31291, 31292, 31293, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335 (Anaes.) Derived fee: 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.)	$379.70
31346	Liposuction (suction assisted lipolysis) to 1 regional area for treatment of contour problems of abdominal or upper arm or thigh fat due to repeated insulin injections, where the lesion is subcutaneous and 50mm or more in diameter (Anaes.)	$333.80
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, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$783.30
31355	Malignant tumour of soft tissue, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where histological proof of malignancy has been obtained, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$1,394.80
31400	Malignant upper aerodigestive tract tumour up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Assist.) (Anaes.)	$564.50
31403	Malignant upper aerodigestive tract tumour more than and including 20mm and up to 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Assist.) (Anaes.)	$650.90
31406	Malignant upper aerodigestive tract tumour more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Assist.) (Anaes.)	$1,020.00
31409	Parapharyngeal tumour, excision of, by cervical approach (Assist.) (Anaes.)	$3,255.40
31412	Recurrent or persistent parapharyngeal tumour, excision of, by cervical approach (Assist.) (Anaes.)	$3,546.60
31420	Lymph node of neck, biopsy of (Anaes.)	$289.50
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 (Assist.) (Anaes.)	$734.30
31426	Lymph nodes of neck, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Assist.) (Anaes.)	$1,875.00
31429	Lymph nodes of neck, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Assist.) (Anaes.)	$2,283.90
31432	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Assist.) (Anaes.)	$3,120.00

31435	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck (Assist.) (Anaes.)	$1,814.10
31438	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido- mastoid muscle, or spinal accessory nerve (Assist.) (Anaes.)	$3,305.00
31441	Long-term implanted reservoir associated with the adjustable gastric band, repair, revision or replacement of (Anaes.)	$396.10
31450	Laparoscopic division of adhesions, as an independent procedure, where the time taken is 1 hour or less (Assist.) (Anaes.)	$676.00
31452	Laparoscopic division of adhesions, as an independent procedure, where the time taken is more than 1 hour (Assist.) (Anaes.)	$1,307.20
31454	Laparoscopy with drainage of pus, bile or blood, as an independent procedure (Assist.) (Anaes.)	$951.10
31456	Gastroscopy and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.)	$386.60
31458	Gastroscopy and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.)	$464.00
31460	Percutaneous gastrostomy tube, jejunal extension to, including any associated imaging services (Assist.) (Anaes.)	$591.40
31462	Operative feeding jejunostomy performed in conjunction with major upper gastro-intestinal resection (Assist.) (Anaes.)	$944.30
31464	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Assist.) (Anaes.)	$1,887.10
31466	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Assist.) (Anaes.)	$2,373.10
31468	Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Assist.) (Anaes.)	$2,606.10
31470	Laparoscopic splenectomy (Assist.) (Anaes.)	$1,316.00
31472	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y as a bypass procedure where prior biliary surgery has been performed (Assist.) (Anaes.)	$1,841.90
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.)	$479.40
31503	Breast, benign lesion more than 50mm in diameter, excision of (Assist.) (Anaes.)	$614.10
31506	Breast, abnormality detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Assist.) (Anaes.)	$715.90
31509	Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (Anaes.)	$575.00
31512	Breast, malignant tumour, complete local excision of, with or without frozen section histology (Assist.) (Anaes.)	$1,186.70
31515	Breast, tumour site, re-excision of following open biopsy or incomplete excision of malignant tumour (Assist.) (Anaes.)	$744.00
31518	Breast (female), total mastectomy (Assist.) (Anaes.)	$1,258.30

31521	Breast (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Assist.) (Anaes.)	$792.80
31524	Breast (female), subcutaneous mastectomy (Assist.) (Anaes.)	$1,774.90
31527	Breast (male), subcutaneous mastectomy, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which 45585 applies (Assist.) (Anaes.)	$960.00
31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated:(a) microcalcification of lesion; or(b) impalpable lesion less than 1cm in diameter- including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply	$960.60
31533	Fine needle aspiration of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.)	$222.30
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.)	$305.40
31539	Breast, biopsy of solid tumour or tissue of, using advanced breast biopsy instrumentation (abbi), for histological examination, when conducted by a surgeon as determined by the Royal australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.)	$631.20
31542	Breast, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to advanced breast biopsy instrumentation (abbi), - including imaging not being a service associated with a service to which item 31536 applies (Anaes.)	$311.70
31545	Breast, biopsy of solid tumour or tissue of, using advanced breast biopsy instrumentation (abbi), for histological examination, when conducted by a surgeon as determined by the Royal australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.)	$942.60
31548	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.)	$240.40
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.)	$349.60
31554	Breast, microdochotomy of, for benign or malignant condition (Assist.) (Anaes.)	$765.20
31557	Breast central ducts, excision of, for benign condition (Assist.) (Anaes.)	$634.30
31560	Accessory breast tissue, excision of (Assist.) (Anaes.)	$640.00
31563	Inverted nipple, surgical eversion of (Anaes.)	$393.90
31566	Accessory nipple, excision of (Anaes.)	$264.70

Colorectal

32000	Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Assist.) (Anaes.)	$1,824.70
32003	Large intestine, resection of, with anastomosis, including right hemicolectomy (Assist.) (Anaes.)	$1,906.50

32004	Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Assist.) (Anaes.)	$2,092.40
32005	Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Assist.) (Anaes.)	$2,369.00
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (Assist.) (Anaes.)	$2,092.40
32009	Total colectomy and ileostomy (Assist.) (Anaes.)	$2,406.20
32012	Total colectomy and ileorectal anastomosis (Assist.) (Anaes.)	$2,658.30
32015	Total colectomy with excision of rectum and ileostomy 1 surgeon (Assist.) (Anaes.)	$3,154.10
32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation; abdominal resection (including aftercare) (Assist.) (Anaes.)	$2,778.60
32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation; perineal resection (Assist.)	$891.20
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.)	$852.20
32024	Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Assist.) (Anaes.)	$2,420.50
32025	Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Assist.) (Anaes.)	$3,222.70
32026	Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Assist.) (Anaes.)	$3,473.20
32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (Assist.) (Anaes.)	$3,887.30
32029	Colonic reservoir, construction of, being a service associated with a service to which any other item in this Subgroup applies (Assist.) (Anaes.)	$741.90
32030	Rectosigmoidectomy (Hartmann's operation) (Assist.) (Anaes.)	$1,876.30
32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma (Assist.) (Anaes.)	$2,748.40
32036	Sacrococcygeal and presacral tumour excision of (Assist.) (Anaes.)	$3,381.60
32039	Rectum and anus, abdominoperineal resection of - 1 surgeon (Assist.) (Anaes.)	$2,753.90
32042	Rectum and anus, abdominoperineal resection of, combined synchronous operation, abdominal resection (Assist.) (Anaes.)	$2,285.90
32045	Rectum and anus, abdominoperineal resection of, combined synchronous operation - perineal resection (Assist.)	$856.60
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.)	$1,363.70
32047	Perineal proctectomy (Assist.) (Anaes.)	$1,587.00

32051	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Assist.) (Anaes.)	$4,089.00
32054	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Assist.) (Anaes.)	$4,461.10
32057	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.)	$1,047.20
32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Assist.) (Anaes.)	$4,089.00
32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Assist.) (Anaes.)	$3,364.90
32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.)	$891.20
32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)	$3,023.50
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
32078	Sigmoidoscopic examination with diathermy or resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes.)	$311.20
32081	Sigmoidoscopic examination with diathermy or resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.)	$421.10
32084	Flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without biopsy (Anaes.)	$204.60
32087	Endoscopic examination of the colon up to the hepatic flexure by flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy for the removal of 1 or more polyps or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, 1 or more of, not being a service to which item 32078 applies (Anaes.)	$373.30
32090	Fibreoptic colonoscopy examination of colon beyond the hepatic flexure with or without biopsy (Anaes.)	$608.30
32093	Endoscopic examination of the colon beyond the hepatic flexure by fibreoptic colonoscopy for the removal of 1 or more polyps, or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, 1 or more of (Anaes.)	$856.80
32094	Endoscopic dilatation of colorectal strictures including colonoscopy (Anaes.)	$1,005.50
32095	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.)	$232.10
32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Assist.) (Anaes.)	$512.20
32099	Rectal tumour of 5cm or less in diameter, per anal submucosal excision of (Assist.) (Anaes.)	$610.20
32102	Rectal tumour of greater than 5cm in diameter, indicated by pathological examination, per anal submucosal excision of (Assist.) (Anaes.)	$1,154.40
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	$1,336.40

	unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Assist.) (Anaes.)	
32104	Rectal tumour, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Assist.) (Anaes.)	$1,732.50
32105	Anorectal carcinoma per anal full thickness excision of (Assist.) (Anaes.)	$856.60
32106	Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Assist.) (Anaes.)	$2,403.90
32108	Rectal tumour, transsphincteric excision of (Kraske or similar operation) (Assist.) (Anaes.)	$1,773.10
32111	Rectal prolapse, Delorme procedure for (Assist.) (Anaes.)	$1,117.10
32112	Rectal prolapse, perineal recto- sigmoidectomy for (Assist.) (Anaes.)	$1,364.90
32114	Rectal stricture, per anal release of (Anaes.)	$305.10
32115	Rectal stricture, dilatation of (Anaes.)	$222.00
32117	Rectal prolapse, abdominal rectopexy of (Assist.) (Anaes.)	$1,773.10
32120	Rectal prolapse, perineal repair of (Assist.) (Anaes.)	$454.00
32123	Anal stricture, anoplasty for (Assist.) (Anaes.)	$588.70
32126	Anal incontinence, Parks' intersphincteric procedure for (Assist.) (Anaes.)	$891.30
32129	Anal sphincter, direct repair of (Assist.) (Anaes.)	$1,117.10
32131	Rectocele, transanal repair of rectocele (Assist.) (Anaes.)	$941.10
32132	Haemorrhoids or rectal prolapse sclerotherapy for (Anaes.)	$80.40
32135	Haemorrhoids or rectal prolapse rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.)	$119.30
32138	Haemorrhoidectomy including excision of anal skin tags when performed (Anaes.)	$678.00
32139	Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Assist.) (Anaes.)	$678.00
32142	Anal skin tags or anal polyps, excision of 1 or more of (Anaes.)	$124.30
32145	Anal skin tags or anal polyps, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.)	$247.70
32147	Perianal thrombosis, incision of (Anaes.)	$75.70
32150	Operation for fissureinano, including excision or sphincterotomy but excluding dilatation only (Assist.) (Anaes.)	$470.20
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.)	$127.50
32156	Fistula-in-ano, subcutaneous, excision of (Anaes.)	$276.20
32159	Anal fistula, treatment of, by excision or by insertion of a seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Assist.) (Anaes.)	$677.50

32162	Anal fistula, treatment of, by excision or by insertion of a seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Assist.) (Anaes.)	$856.60
32165	Anal fistula, repair of by mucosal flap advancement (Assist.) (Anaes.)	$1,117.10
32166	Anal fistula - readjustment of Seton (Anaes.)	$372.50
32168	Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (Anaes.)	$240.50
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.)	$157.50
32174	Intra-anal, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)	$147.60
32175	Intra-anal, perianal or ischio-rectal abscess, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.)	$295.10
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.)	$316.50
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.)	$446.90
32183	Intestinal sling procedure prior to radiotherapy (Assist.) (Anaes.)	$966.90
32186	Colonic lavage, total, intraoperative (Assist.) (Anaes.)	$966.90
32200	Distal muscle, devascularisation of (Assist.) (Anaes.)	$467.90
32203	Anal or perineal graciloplasty (Assist.) (Anaes.)	$1,117.10
32206	Stimulator and electrodes, insertion of, following previous graciloplasty (Assist.) (Anaes.)	$1,009.90
32209	Anal or perineal graciloplasty with insertion of stimulator and electrodes (Assist.) (Anaes.)	$1,459.00
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(s), placement of, percutaneous using fluoroscopic guidance, or open, and intraoperative test stimulation, for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment (Anaes.)	$1,138.00
32214	Neurostimulator or receiver, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non- surgical treatment, using fluoroscopic guidance (Assist.) (Anaes.)	$606.90
32215	Sacral nerve electrode(s), management, adjustment, and electronic programming of neurostimulator by a medical practitioner, for the management of faecal incontinence - each day	$198.90
32216	Sacral nerve lead(s), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non- surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.)	$1,021.90

32217	Neurostimulator or receiver, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non- surgical treatment, removal of (Anaes.)	$269.20
32218	Sacral nerve lead(s), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non- surgical treatment, removal of (Anaes.)	$288.80
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 (Assist.) (Anaes.)	$1,430.40
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 (Assist.) (Anaes.)	$1,455.90

Vascular

32500	Varicose veins where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding aftercare) - to a maximum of 6 treatments in a 12 month period (Anaes.)	$250.00
32501	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) where it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination - and that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period	$173.80
32504	Varicose veins, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.)	$625.00
32507	Varicose veins, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Assist.) (Anaes.)	$983.10
32508	Varicose veins, complete dissection at the sapheno-femoral or sapheno- popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.)	$996.90
32511	Varicose veins, complete dissection at the sapheno-femoral and sapheno- popliteal junction -1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.)	$1,624.10
32514	Varicose veins, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.)	$1,667.40
32517	Varicose veins, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.)	$2,376.90
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	$846.90

	as necessary), using a laser probe introduced by an endovenous catheter, where 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, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507. (Anaes.)	
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, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)	$1,259.20
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, where 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, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)	$818.80
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, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)	$1,217.40
32700	Artery of neck, bypass using vein or synthetic material (Assist.) (Anaes.)	$2,592.70
32703	Internal carotid artery, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Assist.) (Anaes.)	$2,169.00
32708	Aortic bypass for occlusive disease using a straight non-bifurcated graft (Assist.) (Anaes.)	$2,618.60
32710	Aortic bypass for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Assist.) (Anaes.)	$3,170.60
32711	Aortic bypass for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Assist.) (Anaes.)	$3,240.20
32712	Ilio-femoral bypass grafting (Assist.) (Anaes.)	$2,274.70
32715	Axillary or subclavian to femoral bypass grafting to 1 or both femoral arteries (Assist.) (Anaes.)	$1,987.40
32718	Femoro-femoral or ilio-femoral cross- over bypass grafting (Assist.) (Anaes.)	$2,148.40
32721	Renal artery, bypass grafting to (Assist.) (Anaes.)	$3,405.50
32724	Renal arteries (both), bypass grafting to (Assist.) (Anaes.)	$3,872.80
32730	Mesenteric vessel (single), bypass grafting to (Assist.) (Anaes.)	$2,939.20
32733	Mesenteric vessels (multiple), bypass grafting to (Assist.) (Anaes.)	$3,405.50

32736	Inferior mesenteric artery, operation on, when performed in conjunction with another intra-abdominal vascular operation (Assist.) (Anaes.)	$756.70
32739	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Assist.) (Anaes.)	$2,338.60
32742	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Assist.) (Anaes.)	$2,685.30
32745	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Assist.) (Anaes.)	$3,060.30
32748	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Assist.) (Anaes.)	$3,307.50
32751	Femoral artery bypass grafting using synthetic graft, with lower anastomosis above or below the knee (Assist.) (Anaes.)	$2,148.40
32754	Femoral artery bypass grafting, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Assist.) (Anaes.)	$2,685.30
32757	Femoral artery sequential bypass grafting (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Assist.) (Anaes.)	$838.80
32760	Vein, harvesting of, from leg or arm for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Assist.) (Anaes.)	$748.80
32763	Arterial bypass grafting, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$2,148.40
32766	Arterial or venous anastomosis, not being a service to which another item in this Sub-group applies, as an independent procedure (Assist.) (Anaes.)	$2,383.00
32769	Arterial or venous anastomosis not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Assist.) (Anaes.)	$497.70
33050	Bypass grafting to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Assist.) (Anaes.)	$2,637.70
33055	Bypass grafting to replace a popliteal aneurysm using a synthetic graft (Assist.) (Anaes.)	$2,112.90
33070	Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.)	$1,522.00
33075	Aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.)	$1,941.90
33080	Intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.)	$2,368.40
33100	Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (Assist.) (Anaes.)	$2,592.70
33103	Thoracic aneurysm, replacement by graft (Assist.) (Anaes.)	$3,638.90
33109	Thoraco-abdominal aneurysm, replacement by graft including re-implantation of arteries (Assist.) (Anaes.)	$4,409.50
33112	Suprarenal abdominal aortic aneurysm, replacement by graft including re- implantation of arteries (Assist.) (Anaes.)	$3,808.80
33115	Infrarenal abdominal aortic aneurysm, replacement by tube graft not being a service associated with a service to which item 33116 applies (Assist.) (Anaes.)	$2,624.90

33116	Infrarenal abdominal aortic aneurysm, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Assist.) (Anaes.)	$2,311.40
33118	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Assist.) (Anaes.)	$2,991.50
33119	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Assist.) (Anaes.)	$2,847.60
33121	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Assist.) (Anaes.)	$3,520.90
33124	Aneurysm of iliac artery (common, external or internal), replacement by graft - unilateral (Assist.) (Anaes.)	$2,183.80
33127	Aneurysms of iliac arteries (common, external or internal), replacement by graft - bilateral (Assist.) (Anaes.)	$2,511.10
33130	Aneurysm of visceral artery, excision and repair by direct anastomosis or replacement by graft (Assist.) (Anaes.)	$2,493.10
33133	Aneurysm of visceral artery, dissection and ligation of arteries without restoration of continuity (Assist.) (Anaes.)	$1,872.50
33136	False aneurysm, repair of, at aortic anastomosis following previous aortic surgery (Assist.) (Anaes.)	$4,727.50
33139	False aneurysm, repair of, in iliac artery and restoration of arterial continuity (Assist.) (Anaes.)	$2,875.30
33142	False aneurysm, repair of, in femoral artery and restoration of arterial continuity (Assist.) (Anaes.)	$2,685.30
33145	Ruptured thoracic aortic aneurysm, replacement by graft (Assist.) (Anaes.)	$4,586.20
33148	Ruptured thoraco-abdominal aortic aneurysm, replacement by graft (Assist.) (Anaes.)	$5,009.90
33151	Ruptured suprarenal abdominal aortic aneurysm, replacement by graft (Assist.) (Anaes.)	$5,434.10
33154	Ruptured infrarenal abdominal aortic aneurysm, replacement by tube graft (Assist.) (Anaes.)	$4,027.70
33157	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Assist.) (Anaes.)	$4,502.80
33160	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to 1 or both femoral arteries (Assist.) (Anaes.)	$6,165.00
33163	Ruptured iliac artery aneurysm, replacement by graft (Assist.) (Anaes.)	$3,687.70
33166	Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (Assist.) (Anaes.)	$3,332.50
33169	Ruptured aneurysm of visceral artery, simple ligation of (Assist.) (Anaes.)	$2,594.30
33172	Aneurysm of major artery, replacement by graft, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$2,303.30
33175	Ruptured aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.)	$2,133.50
33178	Ruptured aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.)	$2,716.40
33181	Ruptured intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.)	$3,321.10

33500	Artery or arteries of neck, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Assist.) (Anaes.)	$2,075.80
33506	Innominate or subclavian artery, endarterectomy of, including closure by suture (Assist.) (Anaes.)	$2,011.20
33509	Aortic endarterectomy, including closure by suture, not being a service associated with another procedure on the aorta (Assist.) (Anaes.)	$2,589.00
33512	Aorto-iliac endarterectomy (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Assist.) (Anaes.)	$2,695.50
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 (Assist.) (Anaes.)	$3,293.00
33518	Iliac endarterectomy, including closure by suture, not being a service associated with another procedure on the iliac artery (Assist.) (Anaes.)	$2,282.90
33521	Ilio-femoral endarterectomy (1 side), including closure by suture (Assist.) (Anaes.)	$2,473.20
33524	Renal artery, endarterectomy of (Assist.) (Anaes.)	$2,939.20
33527	Renal arteries (both), endarterectomy of (Assist.) (Anaes.)	$3,405.50
33530	Coeliac or superior mesenteric artery, endarterectomy of (Assist.) (Anaes.)	$2,939.20
33533	Coeliac and superior mesenteric artery, endarterectomy of (Assist.) (Anaes.)	$2,986.90
33536	Inferior mesenteric artery, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$2,130.20
33539	Artery of extremities, endarterectomy of, including closure by suture (Assist.) (Anaes.)	$1,790.50
33542	Extended deep femoral endarterectomy where the endarterectomy is at least 7cms long (Assist.) (Anaes.)	$2,494.90
33545	Artery, vein or bypass graft, patch grafting to by vein or synthetic material where patch is less than 3cm long (Assist.) (Anaes.)	$501.50
33548	Artery, vein or bypass graft, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Assist.) (Anaes.)	$1,037.00
33551	Vein, harvesting of from leg or arm for patch when not performed through same incision as operation (Assist.) (Anaes.)	$501.50
33554	Endarterectomy, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Assist.) (Anaes.)	$486.80
33800	Embolus, removal of, from artery of neck (Assist.) (Anaes.)	$2,126.60
33803	Embolectomy or thrombectomy, by abdominal approach, of an artery or bypass graft of trunk (Assist.) (Anaes.)	$2,081.90
33806	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Assist.) (Anaes.)	$1,470.30
33810	Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (Assist.) (Anaes.)	$975.60
33811	Inferior vena cava or iliac vein, open removal of thrombus or tumour (Assist.) (Anaes.)	$3,244.10
33812	Thrombus, removal of, from femoral or other similar large vein (Assist.) (Anaes.)	$1,682.20
33815	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by lateral suture (Assist.) (Anaes.)	$1,526.80

33818	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by direct anastomosis (Assist.) (Anaes.)	$1,780.20
33821	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Assist.) (Anaes.)	$2,076.10
33824	Major artery or vein of neck, repair of wound of, with restoration of continuity, by lateral suture (Assist.) (Anaes.)	$1,943.60
33827	Major artery or vein of neck, repair of wound of, with restoration of continuity, by direct anastomosis (Assist.) (Anaes.)	$2,129.80
33830	Major artery or vein of neck, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Assist.) (Anaes.)	$3,079.30
33833	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by lateral suture (Assist.) (Anaes.)	$2,402.40
33836	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by direct anastomosis (Assist.) (Anaes.)	$2,875.30
33839	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by means of interposition graft (Assist.) (Anaes.)	$3,342.90
33842	Artery of neck, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Assist.) (Anaes.)	$1,668.20
33845	Laparotomy for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Assist.) (Anaes.)	$1,159.00
33848	Extremity, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Assist.) (Anaes.)	$1,159.00
34100	Major artery of neck, elective ligation or exploration of, not being a service associated with any other vascular procedure (Assist.) (Anaes.)	$1,278.80
34103	Great artery or great vein (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Assist.) (Anaes.)	$756.80
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 (Assist.) (Anaes.)	$685.00
34109	Temporal artery, biopsy of (Assist.) (Anaes.)	$616.30
34112	Arterio-venous fistula of an extremity, dissection and ligation (Assist.) (Anaes.)	$1,547.70
34115	Arterio-venous fistula of the neck, dissection and ligation (Assist.) (Anaes.)	$1,790.50
34118	Arterio-venous fistula of the abdomen, dissection and ligation (Assist.) (Anaes.)	$2,189.60
34121	Arterio-venous fistula of an extremity, dissection and repair of, with restoration of continuity (Assist.) (Anaes.)	$2,000.30
34124	Arterio-venous fistula of the neck, dissection and repair of, with restoration of continuity (Assist.) (Anaes.)	$1,916.10
34127	Arterio-venous fistula of the abdomen, dissection and repair of, with restoration of continuity (Assist.) (Anaes.)	$2,511.10
34130	Surgically created arterio-venous fistula of an extremity, closure of (Assist.) (Anaes.)	$905.00
34133	Scalenotomy (Assist.) (Anaes.)	$1,007.40
34136	First rib, resection of portion of (Assist.) (Anaes.)	$1,676.30
34139	Cervical rib, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$1,611.70

34142	Coeliac artery, decompression of, for coeliac artery compression syndrome, as an independent procedure (Assist.) (Anaes.)	$2,331.00
34145	Popliteal artery, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Assist.) (Anaes.)	$1,581.60
34148	Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Assist.) (Anaes.)	$3,380.00
34151	Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Assist.) (Anaes.)	$3,533.10
34154	Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Assist.) (Anaes.)	$4,239.80
34157	Neck, excision of infected bypass graft, including closure of vessel or vessels (Assist.) (Anaes.)	$1,880.40
34160	Aorto-duodenal fistula, repair of, by suture of aorta and repair of duodenum (Assist.) (Anaes.)	$3,522.60
34163	Aorto-duodenal fistula, repair of, by insertion of aortic graft and repair of duodenum (Assist.) (Anaes.)	$4,522.20
34166	Aorto-duodenal fistula, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo bifemoral grafting (Assist.) (Anaes.)	$5,190.80
34169	Infected bypass graft from trunk, excision of, including closure of arteries (Assist.) (Anaes.)	$2,875.30
34172	Infected axillo-femoral or femoro- femoral graft, excision of, including closure of arteries (Assist.) (Anaes.)	$2,338.60
34175	Infected bypass graft from extremities, excision of including closure of arteries (Assist.) (Anaes.)	$2,148.40
34500	Arteriovenous shunt, external, insertion of (Assist.) (Anaes.)	$487.90
34503	Arteriovenous anastomosis of upper or lower limb, in conjunction with another venous or arterial operation (Assist.) (Anaes.)	$764.50
34506	Arteriovenous shunt, external, removal of (Assist.) (Anaes.)	$386.50
34509	Arteriovenous anastomosis of upper or lower limb, not in conjunction with another venous or arterial operation (Assist.) (Anaes.)	$1,759.80
34512	Arteriovenous access device, insertion of (Assist.) (Anaes.)	$1,943.10
34515	Arteriovenous access device, thrombectomy of (Assist.) (Anaes.)	$1,384.70
34518	Stenosis of arteriovenous fistula or prosthetic arteriovenous access device, correction of (Assist.) (Anaes.)	$2,325.10
34521	Intra-abdominal artery or vein, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Assist.) (Anaes.)	$991.20
34524	Arterial cannulation for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Assist.) (Anaes.)	$748.80
34527	Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.)	$864.10
34528	Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.)	$494.10

34530	Hickman or broviac catheter, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital (Anaes.)	$330.80
34533	Isolated limb perfusion, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Assist.) (Anaes.)	$2,230.30
34538	Central vein catherterisation by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis parenteral or nutrition (Anaes.)	$450.10
34539	Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.)	$337.80
34800	Inferior vena cava, plication, ligation, or application of caval clip (Assist.) (Anaes.)	$1,827.60
34803	Inferior vena cava, reconstruction of or bypass by vein or synthetic material (Assist.) (Anaes.)	$3,563.50
34806	Cross leg bypass grafting, saphenous to iliac or femoral vein (Assist.) (Anaes.)	$1,535.20
34809	Saphenous vein anastomosis to femoral or popliteal vein for femoral vein bypass (Assist.) (Anaes.)	$1,535.20
34812	Venous stenosis or occlusion, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Assist.) (Anaes.)	$2,198.10
34815	Vein stenosis, patch angioplasty for, (excluding vein graft stenosis) - using vein or synthetic material (Assist.) (Anaes.)	$1,790.50
34818	Venous valve, plication or repair to restore valve competency (Assist.) (Anaes.)	$1,929.60
34821	Vein transplant to restore valvular function (Assist.) (Anaes.)	$2,296.80
34824	External stent, application of, to restore venous valve competency to superficial vein - 1 stent (Assist.) (Anaes.)	$1,175.00
34827	External stents, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Assist.) (Anaes.)	$1,288.40
34830	External stent, application of, to restore venous valve competency to deep vein (1 stent) (Assist.) (Anaes.)	$1,118.80
34833	External stents, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Assist.) (Anaes.)	$1,451.80
35000	Lumbar sympathectomy (Assist.) (Anaes.)	$1,278.80
35003	Cervical or upper thoracic sympathectomy by any surgical approach (Assist.) (Anaes.)	$1,943.90
35006	Cervical or upper thoracic sympathectomy, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Assist.) (Anaes.)	$2,048.00
35009	Lumbar sympathectomy, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Assist.) (Anaes.)	$1,628.40
35012	Sacral or pre-sacral sympathectomy (Assist.) (Anaes.)	$1,359.50
35100	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Assist.) (Anaes.)	$647.40
35103	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.)	$416.90
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.)	$324.10
35202	Major arteries or veins in the neck, abdomen or extremities, access to, as part of re-operation after prior surgery on these vessels (Assist.) (Anaes.)	$1,526.20

35300	Transluminal balloon angioplasty of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$946.50
35303	Transluminal balloon angioplasty of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,215.30
35306	Transluminal stent insertion including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,161.00
35307	Transluminal stent insertion, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who: - meet the indications for carotid endarterectomy; and - have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,930.20
35309	Transluminal stent insertion including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,405.50
35312	Peripheral arterial atherectomy including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,582.60
35315	Peripheral laser angioplasty including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,701.70
35317	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by continuous infusion, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Assist.) (Anaes.)	$651.30
35319	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by pulse spray technique, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Assist.) (Anaes.)	$1,148.30
35320	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by open exposure, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Assist.) (Anaes.)	$1,408.90
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 (Assist.) (Anaes.)	$1,492.50
35324	Angioscopy not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$560.10
35327	Angioscopy combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$646.80

35330	Insertion of inferior vena caval filter, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$928.50
35331	Retrieval of inferior vena caval filter, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.)	$1,000.00
35360	Retrieval of foreign body in pulmonary artery, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Assist.) (Anaes.)	$1,310.60
35361	Retrieval of foreign body in right atrium, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Assist.) (Anaes.)	$1,198.90
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) (Assist.) (Anaes.)	$1,000.00
35363	Retrieval of foreign body in peripheral vein or peripheral artery, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Assist.) (Anaes.)	$883.70
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.	$545.80
35406	Trans-femoral catheterisation of the hepatic artery to administer sir- Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5- fluorouracil (5fu) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,280.50
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer sir-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5fu) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$960.50
35410	Uterine artery catheterisation with percutaneous adminstration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,280.50
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including intra-operative imaging, but in association with pre-operative diagnostic imaging items 60009 and either 60072, 60075 or 60078, including aftercare (Assist.) (Anaes.)	$4,499.10

Gynaecological

35500	Gynaecological examination under anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)	$148.80

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.)	$141.00
35503	Intrauterine contraceptive device, introduction of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$96.90
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.)	$87.50
35507	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.)	$336.40
35508	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Assist.) (Anaes.)	$469.70
35509	Hymenectomy (Anaes.)	$183.50
35512	Bartholin's cyst, excision of (Anaes.)	$317.70
35513	Bartholin's cyst, excision of (Anaes.)	$414.00
35516	Bartholin's cyst or gland, marsupialisation of (Anaes.)	$249.90
35517	Bartholin's cyst or gland, marsupialisation of (Anaes.)	$287.90
35518	Ovarian cyst aspiration, for cysts of at least 4cm in diameter in premenopausal women and at least 2cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.)	$337.00
35520	Bartholin's abscess, incision of (Anaes.)	$99.40
35523	Urethra or urethral caruncle, cauterisation of (Anaes.)	$126.00
35526	Urethral caruncle, excision of (Anaes.)	$239.00
35527	Urethral caruncle, excision of (Anaes.)	$308.20
35530	Clitoris, amputation of, where medically indicated (Assist.) (Anaes.)	$580.00
35533	Vulvoplasty or labioplasty, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.)	$760.00
35536	Vulva, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Assist.) (Anaes.)	$654.30
35539	Colposcopically directed CO? laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.)	$499.80
35542	Colposcopically directed CO? laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Assist.) (Anaes.)	$658.00
35545	Colposcopically directed CO? laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)	$289.20
35548	Vulvectomy, radical, for malignancy (Assist.) (Anaes.)	$1,550.70
35551	Pelvic lymph glands, excision of (radical) (Assist.) (Anaes.)	$1,427.00
35554	Vagina, dilatation of, as an independent procedure including any associated consultation (Anaes.)	$68.40
35557	Vagina, removal of simple tumour (including Gartner duct cyst) (Anaes.)	$392.90

35560	Vagina, partial or complete removal of (Assist.) (Anaes.)	$1,248.30
35561	Vaginectomy, radical, for proven invasive malignancy - 1 surgeon (Assist.) (Anaes.)	$2,526.40
35562	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Assist.) (Anaes.)	$1,783.30
35564	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.)	$1,225.00
35565	Vaginal reconstruction for congenital absence, gynatresia or urogenital sinus (Assist.) (Anaes.)	$1,531.00
35566	Vaginal septum, excision of, for correction of double vagina (Assist.) (Anaes.)	$719.40
35568	Sacrospinous colpopexy for management of upper vaginal prolapse (Assist.) (Anaes.)	$1,200.20
35569	Plastic repair to enlarge vaginal orifice (Anaes.)	$290.70
35570	Anterior vaginal compartment repair by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Assist.) (Anaes.)	$1,010.60
35571	Posterior vaginal compartment repair by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Assist.) (Anaes.)	$1,020.40
35572	Colpotomy, not being a service to which another item in this Group applies (Anaes.)	$226.40
35573	Anterior and posterior vaginal compartment repair by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh, not being a service associated with a service to which item 35577 or 35578 applies (Assist.) (Anaes.)	$1,545.20
35577	Manchester (donald fothergill) operation for genital prolapse, with or without mesh (Assist.) (Anaes.)	$1,213.70
35578	Le fort operation for genital prolapse, not being a service associated with a service to which another item in this Subroup applies (Assist.) (Anaes.)	$1,223.90
35595	Laparoscopic or abdominal pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse (Assist.) (Anaes.)	$2,139.70
35596	Fistula between genital and urinary or alimentary tracts, repair of, not being a service to which item 37029, 37333 or 37336 applies (Assist.) (Anaes.)	$1,249.00
35597	Sacral colpopexy, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Assist.) (Anaes.)	$2,938.60
35599	Stress incontinence, sling operation forwith or without mesh or tape, not being a service associated with a service to which item 30405 applies (Assist.) (Anaes.)	$1,249.60
35602	Stress incontinence, combined synchronous abdominovaginal operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) (Anaes.)	$1,465.00
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.)	$675.40
35608	Cervix, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.)	$115.20
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.)	$109.40
35612	Cervix, residual stump, removal of, by abdominal approach (Assist.) (Anaes.)	$876.50

35613	Cervix, residual stump, removal of, by vaginal approach (Assist.) (Anaes.)	$659.10
35614	Examination of lower female genital tract by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.)	$118.00
35615	Vulva, biopsy of, when performed in conjunction with a service to which item 35614 applies	$101.60
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.)	$838.00
35617	Cervix, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.)	$355.70
35618	Cervix, cone biopsy, amputation or repair of, not being a service to which item 35584 applies (Anaes.)	$450.60
35620	Endometrial biopsy where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.)	$99.80
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.)	$1,095.90
35623	Hysteroscopic resection of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.)	$1,471.20
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	$154.40
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.)	$1,088.20
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 (Assist.) (Anaes.)	$760.30
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	$1,412.30

	retroperitoneal procedure except item 30393 (Assist.) (Anaes.)	
35639	Uterus, curettage of, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)	$212.50
35640	Uterus, curettage of, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)	$336.40
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 (Assist.) (Anaes.)	$2,687.90
35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage not being a service to which item 35639 or 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)	$343.30
35644	Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.)	$320.70
35645	Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in association with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35649 applies (Anaes.)	$545.50
35646	Cervix, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital (Anaes.)	$365.20
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.)	$578.60
35649	Hysterotomy or uterine myomectomy, abdominal (Assist.) (Anaes.)	$1,055.00
35653	Hysterectomy, abdominal, sub total or total, with or without removal of uterine adnexae (Assist.) (Anaes.)	$1,264.90
35657	Hysterectomy, vaginal, with or without uterine curettage, not being a service to which item 35673 applies. note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Assist.) (Anaes.)	$1,222.20
35658	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Assist.) (Anaes.)	$816.60
35661	Hysterectomy, abdominal, requiring extensive retroperitoneal dissection with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic	$1,712.40

	inflammatory disease or benign pelvic tumours, with or without conservation of ovaries (Assist.) (Anaes.)	
35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Assist.) (Anaes.)	$2,767.70
35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Assist.) (Anaes.)	$2,374.10
35670	Hysterectomy, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Assist.) (Anaes.)	$1,895.60
35673	Hysterectomy, vaginal, (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Assist.) (Anaes.)	$1,382.20
35674	Ultrasound guided needling and injection of ectopic pregnancy	$327.40
35676	Ectopic pregnancy, removal of (Assist.) (Anaes.)	$743.40
35677	Ectopic pregnancy, removal of (Assist.) (Anaes.)	$963.20
35678	Ectopic pregnancy, laparoscopic removal of (Assist.) (Anaes.)	$1,178.40
35680	Bicornuate uterus, plastic reconstruction for (Assist.) (Anaes.)	$1,219.10
35683	Uterus, suspension or fixation of, as an independent procedure (Assist.) (Anaes.)	$790.00
35684	Uterus, suspension or fixation of, as an independent procedure (Assist.) (Anaes.)	$833.70
35687	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Assist.) (Anaes.)	$594.80
35688	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Assist.) (Anaes.)	$723.50
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. (Assist.) (Anaes.)	$267.10
35694	Tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, 1 or more procedures (Assist.) (Anaes.)	$1,204.70
35697	Microsurgical tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, 1 or more procedures (Assist.) (Anaes.)	$1,670.10
35700	Fallopian tubes, unilateral microsurgical anastomosis of, using operating microscope (Assist.) (Anaes.)	$1,575.00
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.)	$78.40
35710	Falloposcopy, unilateral or bilateral, including hysteroscopy and tubal catheterization (Assist.) (Anaes.)	$926.60

35712	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst - 1 such procedure, not being a service associated with hysterectomy (Assist.) (Anaes.)	$666.80
35713	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst 1 such procedure, not being a service associated with hysterectomy (Assist.) (Anaes.)	$832.40
35716	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Assist.) (Anaes.)	$772.90
35717	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Assist.) (Anaes.)	$992.20
35720	Radical or debulking operation for advanced gynaecological malignancy, with or without omentectomy (Assist.) (Anaes.)	$1,315.00
35723	Retroperitoneal lymph node biopsies from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Assist.) (Anaes.)	$943.50
35726	Infracolic omentectomy with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Assist.) (Anaes.)	$958.30
35729	Ovarian transposition out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)	$478.40
35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy (Assist.) (Anaes.)	$1,553.40
35753	Laparoscopically assisted hysterectomy with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Assist.) (Anaes.)	$1,819.90
35754	Laparoscopically assisted hysterectomy which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Assist.) (Anaes.)	$2,416.50
35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy (Assist.) (Anaes.)	$1,506.30
35759	Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Assist.) (Anaes.)	$971.30
	Urological	
36500	Adrenal gland, excision of partial or total (Assist.) (Anaes.)	$1,690.70
36502	Pelvic lymphadenectomy, open or laparoscopic, or both, unilateral or bilateral (Assist.) (Anaes.)	$1,475.00
36503	Renal transplant, not being a service to which item 36506 or 36509 applies (Assist.) (Anaes.)	$2,360.30
36506	Renal transplant, performed by vascular surgeon and urologist operating together vascular anastomosis, including aftercare (Assist.) (Anaes.)	$1,571.30
36509	Renal transplant, performed by vascular surgeon and urologist operating together ureterovesical anastomosis, including aftercare (Assist.)	$1,340.50
36516	Nephrectomy, complete (Assist.) (Anaes.)	$1,773.70

36519	Nephrectomy, complete, complicated by previous surgery on the same kidney (Assist.) (Anaes.)	$2,372.10
36522	Nephrectomy, partial (Assist.) (Anaes.)	$2,285.00
36525	Nephrectomy, partial, complicated by previous surgery on the same kidney (Assist.) (Anaes.)	$3,235.00
36526	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Assist.) (Anaes.)	$2,665.00
36527	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Assist.) (Anaes.)	$3,206.30
36528	nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Assist.) (Anaes.)	$2,665.00
36529	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Assist.) (Anaes.)	$3,224.10
36531	Nephroureterectomy, complete, including associated bladder repair and any associated endoscopic procedure (Assist.) (Anaes.)	$2,370.60
36532	Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Assist.) (Anaes.)	$3,348.30
36533	Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Assist.) (Anaes.)	$3,616.30
36537	Kidney or perinephric area, exploration of, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$1,217.50
36540	Nephrolithotomy or pyelolithotomy, or both, through the same skin incision, for 1 or 2 stones (Assist.) (Anaes.)	$2,028.60
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Assist.) (Anaes.)	$2,467.10
36546	Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultations, unilateral (Anaes.)	$1,230.30
36549	Ureterolithotomy (Assist.) (Anaes.)	$1,438.50
36552	Nephrostomy or pyelostomy, open, as an independent procedure (Assist.) (Anaes.)	$1,258.80
36558	Renal cyst or cysts, excision or unroofing of (Assist.) (Anaes.)	$1,335.00
36561	Renal biopsy (closed) (Anaes.)	$286.30
36564	Pyeloplasty, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Assist.) (Anaes.)	$1,905.00
36567	Pyeloplasty in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Assist.) (Anaes.)	$1,727.30
36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open exposure (Assist.) (Anaes.)	$2,665.00
36573	Divided ureter, repair of (Assist.) (Anaes.)	$1,594.00
36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, not	$2,380.00

	being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Assist.) (Anaes.)	
36579	Ureterectomy, complete or partial, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Assist.) (Anaes.)	$1,525.00
36585	Ureter, transplantation of, into skin (Assist.) (Anaes.)	$1,173.60
36588	Ureter, reimplantation into bladder (Assist.) (Anaes.)	$1,571.30
36591	Ureter, reimplantation into bladder with psoas hitch or Boari flap or both (Assist.) (Anaes.)	$2,013.80
36594	Ureter, transplantation of, into intestine (Assist.) (Anaes.)	$1,796.40
36597	Ureter, transplantation of, into another ureter (Assist.) (Anaes.)	$1,664.10
36600	Ureter, transplantation of, into isolated intestinal segment, unilateral (Assist.) (Anaes.)	$1,964.40
36603	Ureters, transplantation of, into isolated intestinal segment, bilateral (Assist.) (Anaes.)	$2,368.10
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.)	$461.30
36605	Ureteric stent, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.)	$1,093.00
36606	Intestinal urinary reservoir, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Assist.) (Anaes.)	$4,204.10
36607	Ureteric stent insertion of, with baloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.)	$1,177.40
36608	Ureteric stent, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.)	$481.70
36609	Intestinal urinary conduit or ureterostomy, revision of (Assist.) (Anaes.)	$1,338.50
36612	Ureter, exploration of, with or without drainage of, as an independent procedure (Assist.) (Anaes.)	$1,175.40
36615	Ureterolysis, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Assist.) (Anaes.)	$1,439.90
36618	Reduction ureteroplasty (Assist.) (Anaes.)	$1,028.40
36621	Closure of cutaneous ureterostomy (Assist.) (Anaes.)	$749.70
36624	Nephrostomy, percutaneous, using interventional imaging techniques (Assist.) (Anaes.)	$945.30
36627	Nephroscopy, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.)	$1,215.70
36630	Nephroscopy, being a service to which item 36627 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (Assist.) (Anaes.)	$581.50
36633	Nephroscopy, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Assist.) (Anaes.)	$1,258.80
36636	Nephroscopy, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Assist.) (Anaes.)	$820.00

36639	Nephroscopy, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.)	$1,508.70
36642	Nephroscopy, being a service to which item 36639 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (Assist.) (Anaes.)	$714.00
36645	Nephroscopy, percutaneous, with removal or destruction of a stone greater than 3cm in any dimension, or for 3 or more stones (Assist.) (Anaes.)	$1,916.60
36648	Nephroscopy, being a service to which item 36645 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation (Assist.) (Anaes.)	$1,706.80
36649	Nephrostomy drainage tube, exchange of - but not including imaging (Assist.) (Anaes.)	$461.30
36650	Nephrostomy tube, removal of, if the ureter has been stented with a double j ureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.)	$252.70
36652	Pyeloscopy, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Assist.) (Anaes.)	$1,160.20
36654	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Assist.)	$1,512.80
36656	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Assist.) (Anaes.)	$1,943.70
36658	Sacral nerve stimulation for refractory urinary incontinence or urge retention, removal of pulse generator and leads	$833.00
36660	Sacral nerve stimulation for refractory urinary incontinence or urge retention, removal and replacement of pulse generator	$404.40
36662	Sacral nerve stimulation for refractory urinary incontinence or urge retention, removal and replacement of leads	$965.80
36663	Sacral nerve lead(s), percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage: a) detrusor overactivity; or b) non obstructive urinary retentionthat has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age older. (Anaes.)	$1,238.80
36664	Sacral nerve lead(s), percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning) and intraoperative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age older, not being a service to which item 36663 applies (Anaes.)	$939.10
36665	Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention - each day	$198.40
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age older. (anaes.)	$759.00

36667	Sacral nerve lead(s), removal of, if the lead was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retentionthat has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age older. (anaes.)	$247.40
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retentionthat has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age older. (anaes.)	$247.40
36800	Bladder, catheterisation of, where no other procedure is performed (Anaes.)	$47.30
36803	Ureteroscopy, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Assist.) (Anaes.)	$849.10
36806	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Assist.) (Anaes.)	$1,199.00
36809	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Assist.) (Anaes.)	$1,535.20
36811	Cystoscopy with insertion of urethral prosthesis (Anaes.)	$597.50
36812	Cystoscopy with urethroscopy, with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.)	$303.50
36815	Cystoscopy, with or without urethroscopy, for the treatment of penile warts or urethral warts, not being a service associated with a service to which item 30189 applies (Anaes.)	$439.50
36818	Cystoscopy, with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Assist.) (Anaes.)	$505.70
36821	Cystoscopy with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Assist.) (Anaes.)	$594.70
36824	Cystoscopy with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.)	$440.00
36825	Cystoscopy, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Assist.) (Anaes.)	$1,184.80
36827	Cystoscopy, with controlled hydrodilatation of the bladder (Anaes.)	$415.20
36830	Cystoscopy, with ureteric meatotomy (Anaes.)	$372.30
36833	Cystoscopy with removal of ureteric stent or other foreign body (Assist.) (Anaes.)	$500.20
36836	Cystoscopy, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes.)	$423.40
36840	Cystoscopy, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.)	$594.20
36842	Cystoscopy, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812,	$561.40

	36827 to 36863, 37203 or 37206 apply (Assist.) (Anaes.)	
36845	Cystoscopy, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.)	$1,253.50
36848	Cystoscopy with resection of ureterocele (Anaes.)	$440.70
36851	Cystoscopy with injection into bladder wall (Anaes.)	$437.90
36854	Cystoscopy with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.)	$855.90
36857	Endoscopic manipulation or extraction of ureteric calculus (Anaes.)	$691.60
36860	Endoscopic examination of intestinal conduit or reservoir (Anaes.)	$289.40
36863	Litholapaxy, with or without cystoscopy (Assist.) (Anaes.)	$842.70
37000	Bladder, partial excision of (Assist.) (Anaes.)	$1,509.80
37004	Bladder, repair of rupture (Assist.) (Anaes.)	$1,103.10
37008	Cystostomy or cystotomy, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.)	$765.00
37011	Suprapubic stab cystotomy, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.)	$190.00
37014	Bladder, total excision of (Assist.) (Anaes.)	$2,156.10
37020	Bladder diverticulum, excision or obliteration of (Assist.) (Anaes.)	$1,422.10
37023	Vesical fistula, cutaneous, operation for (Anaes.)	$855.00
37026	Cutaneous vesicostomy, establishment of (Assist.) (Anaes.)	$659.00
37029	Vesicovaginal fistula, closure of by abdominal approach (Assist.) (Anaes.)	$1,601.40
37038	Vesicointestinal fistula, closure of, excluding bowel resection (Assist.) (Anaes.)	$1,306.70
37041	Bladder aspiration, by needle	$85.80
37042	Bladder stress incontinence, sling procedure for, using autologous fascial sling, with or without mesh, including harvesting of sling, not being a service associated with a service to which item 30405 or 35599 applies (Assist.) (Anaes.)	$1,752.20
37043	Bladder stress incontinence, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Assist.) (Anaes.)	$1,221.30
37044	Bladder stress incontinence, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Assist.) (Anaes.)	$1,346.50
37045	Mitrofanoff continent valve, formation of (Assist.) (Anaes.)	$2,756.10
37047	Bladder enlargement using intestine (Assist.) (Anaes.)	$2,830.20
37050	Bladder exstrophy closure, not involving sphincter reconstruction (Assist.) (Anaes.)	$1,258.80
37053	Bladder transection and re-anastomosis to trigone (Assist.) (Anaes.)	$1,355.80
37200	Prostatectomy, open (Assist.) (Anaes.)	$2,095.00
37201	Prostate, transurethral radio- frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.)	$1,607.30
37202	Prostate, transurethral radio- frequency needle ablation of, with or without cystoscopy and	$658.40

	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.)	
37203	Prostatectomy (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.)	$2,028.30
37206	Prostatectomy (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.)	$1,140.00
37207	Prostate, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37321 or 37324 applies (Anaes.)	$1,775.00
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.)	$704.80
37209	Prostate, and/or seminal vesicle/ampulla of vas, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Assist.) (Anaes.)	$2,665.00
37210	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Assist.) (Anaes.)	$3,275.00
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, with pelvic lymphadenectomy, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Assist.) (Anaes.)	$3,980.00
37212	Prostate, open perineal biopsy or open drainage of abscess (Assist.) (Anaes.)	$437.70
37215	prostate, biopsy of, endoscopic, with or without cystoscopy (Assist.) (Anaes.)	$766.00
37217	Prostate, implantation of gold fiducial markers into the prostate gland or prostate surgical bed (Anaes.)	$215.20
37218	prostate, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.)	$242.20
37219	Prostate, needle biopsy of, using prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Assist.) (Anaes.)	$513.40
37220	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages t1 (clinically inapparent tumour not palpable or visible by imaging) or t2 (tumour confined within prostate), with a gleason score of less than or equal to 7 and a prostate specific antigen (psa) of less than or equal to 10ng/ml at the time of diagnosis. the procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. (Anaes.)	$2,185.00
37221	Prostatic abscess, endoscopic drainage of (Assist.) (Anaes.)	$950.00
37223	Prostatic coil, insertion of, under ultrasound control (Anaes.)	$351.30
37224	Prostate, diathermy or visual laser destruction of lesion of, not being a service associated	$617.10

	with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.)	
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.)	$2,185.00
37230	Prostate, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.)	$2,380.00
37233	Prostate, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37203, 37207, 37201, 37230 which had to be discontinued for medical reasons (Anaes.)	$878.80
37245	Prostate, endoscopic enucleation of, using high powered holmium:yag laser and an end-firing, non-contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia, and other than a service associated with a service to which item 36854, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321, or 37324 applies. (Anaes.)	$1,936.70
37300	Urethral sounds, passage of, as an independent procedure (Anaes.)	$78.20
37303	Urethral stricture, dilatation of (Anaes.)	$126.90
37306	Urethra, repair of rupture of distal section (Assist.) (Anaes.)	$1,118.20
37309	Urethra, repair of rupture of prostatic or membranous segment (Assist.) (Anaes.)	$1,664.40
37315	Urethroscopy, as an independent procedure (Anaes.)	$235.00
37318	Urethroscopy, with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Assist.) (Anaes.)	$510.20
37321	Urethral meatotomy, external (Anaes.)	$173.30
37324	Urethrotomy or urethrostomy, internal or external (Anaes.)	$440.00
37327	Urethrotomy, optical, for urethral stricture (Assist.) (Anaes.)	$593.00
37330	Urethrectomy, partial or complete, for removal of tumour (Assist.) (Anaes.)	$1,218.10
37333	Urethrovaginal fistula, closure of (Assist.) (Anaes.)	$883.20
37336	Urethrorectal fistula, closure of (Assist.) (Anaes.)	$1,258.80
37339	Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.)	$430.50
37340	Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Assist.) (Anaes.)	$749.60
37341	Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Assist.) (Anaes.)	$1,665.90
37342	Urethroplasty single stage operation (Assist.) (Anaes.)	$1,715.00
37343	Urethroplasty, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Assist.) (Anaes.)	$2,552.50
37345	Urethroplasty 2 stage operation first stage (Assist.) (Anaes.)	$1,430.00
37348	Urethroplasty 2 stage operation second stage (Assist.) (Anaes.)	$1,430.00

37351	Urethroplasty, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$501.90
37354	Hypospadias, meatotomy and hemicircumcision (Assist.) (Anaes.)	$670.00
37369	Urethra, excision of prolapse of (Anaes.)	$338.90
37372	Urethral diverticulum, excision of (Assist.) (Anaes.)	$872.30
37375	Urethral sphincter, reconstruction by bladder tubularisation technique or similar procedure (Assist.) (Anaes.)	$2,380.00
37381	Artificial urinary sphincter, insertion of cuff, perineal approach (Assist.) (Anaes.)	$1,525.00
37384	Artificial urinary sphincter, insertion of cuff, abdominal approach (Assist.) (Anaes.)	$2,380.00
37387	Artificial urinary sphincter, insertion of pressure regulating balloon and pump (Assist.) (Anaes.)	$665.00
37390	Artificial urinary sphincter, revision or removal of, with or without replacement (Assist.) (Anaes.)	$1,691.10
37393	Priapism, decompression by glanular stab caverno-sospongiosum shunt or penile aspiration with or without lavage (Anaes.)	$395.40
37396	Priapism, shunt operation for, not being a service to which item 37393 applies (Assist.) (Anaes.)	$1,173.60
37402	Penis, partial amputation of (Assist.) (Anaes.)	$950.00
37405	Penis, complete or radical amputation of (Assist.) (Anaes.)	$1,905.00
37408	Penis, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Assist.) (Anaes.)	$950.00
37411	Penis, repair of avulsion (Assist.) (Anaes.)	$1,463.30
37415	Penis, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months	$78.70
37417	Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Assist.) (Anaes.)	$1,140.00
37418	Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Assist.) (Anaes.)	$1,525.00
37420	Penis, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins, with or without pharmacological erection test (Assist.) (Anaes.)	$579.80
37423	Penis, lengthening by translocation of corpora (Assist.) (Anaes.)	$1,905.00
37426	Penis, artificial erection device, insertion of, into 1 or both corpora (Assist.) (Anaes.)	$2,000.00
37429	Penis, artificial erection device, insertion of pump and pressure regulating reservoir (Assist.) (Anaes.)	$665.00
37432	Penis, artificial erection device, complete or partial revision or removal of components, with or without replacement (Assist.) (Anaes.)	$1,769.80
37435	Penis, frenuloplasty as an independent procedure (Anaes.)	$190.00
37438	Scrotum, partial excision of (Assist.) (Anaes.)	$513.20
37444	Ureterolithotomy complicated by previous surgery at the same site of the same ureter (Assist.) (Anaes.)	$1,581.90
37601	Spermatocele or epididymal cyst, excision of, 1 or more of, on 1 side (Anaes.)	$527.50
37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for ivf (Anaes.)	$565.00

37605	Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes of intracytoplasmic sperm injection, in a man with male factor infertility, excluding a service to which item 13218 applies. (Anaes.)	$688.40
37606	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of intracytoplasmic sperm injection, in a man with male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.)	$1,009.50
37607	Retroperitoneal lymph node dissection, unilateral, not being a service associated with a service to which item 36528 applies (Assist.) (Anaes.)	$1,778.80
37610	Retroperitoneal lymph node dissection, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Assist.) (Anaes.)	$2,353.10
37613	Epididymectomy (Anaes.)	$570.00
37616	Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, not being a service associated with sperm harvesting for IVF (Assist.) (Anaes.)	$2,050.50
37619	Vasovasostomy or vasoepididymostomy, unilateral, not being a service associated with sperm harvesting for IVF (Assist.) (Anaes.)	$1,176.10
37622	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.)	$424.80
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 (Assist.) (Anaes.)	$945.40
37803	Undescended testis, orchidopexy for, not being a service to which item 37806 applies (Assist.) (Anaes.)	$959.90
37806	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Assist.) (Anaes.)	$1,026.40
37809	Undescended testis, revision orchidopexy for (Assist.) (Anaes.)	$1,001.00
37812	Impalpable testis, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 apply (Assist.) (Anaes.)	$974.50
37815	Hypospadias, examination under anaesthesia with erection test (Anaes.)	$167.30
37818	Hypospadias, glanuloplasty incorporating meatal advancement (Assist.) (Anaes.)	$789.90
37821	Hypospadias, distal, 1 stage repair (Assist.) (Anaes.)	$1,485.90
37824	Hypospadias, proximal, 1 stage repair (Assist.) (Anaes.)	$2,380.00
37827	Hypospadias, staged repair, first stage (Assist.) (Anaes.)	$840.10
37830	Hypospadias, staged repair, second stage (Assist.) (Anaes.)	$1,088.60
37833	Hypospadias, repair of post operative urethral fistula (Assist.) (Anaes.)	$668.60
37836	Epispadias, staged repair, first stage (Assist.) (Anaes.)	$1,094.40
37839	Epispadias, staged repair, second stage (Assist.) (Anaes.)	$1,240.10
37842	Exstrophy of bladder or epispadias, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Assist.) (Anaes.)	$2,894.60
37845	Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with or without endoscopy (Assist.) (Anaes.)	$1,094.40

37848	Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with endoscopy and vaginoplasty (Assist.) (Anaes.)	$1,969.60
37851	Congenital adrenal hyperplasia, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Assist.) (Anaes.)	$1,459.20
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (Assist.) (Anaes.)	$631.80
	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.)	$678.00
38203	Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventri cular 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.)	$870.10
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.)	$1,123.70
38209	Cardiac electrophysiological study up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.)	$1,181.70
38212	Cardiac electrophysiological study 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation or testing not being a service associated with a service to which item 38209 or 38213 applies (Anaes.)	$2,022.00
38213	Cardiac electrophysiological study, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.)	$738.60
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.)	$647.10
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.)	$1,072.60
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.)	$325.30
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.)	$561.50
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,	$1,006.70

	38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	
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.)	$1,305.60
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.)	$1,627.50
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.)	$1,342.10
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.)	$1,677.60
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.)	$2,013.30
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 inconlclusive (Anaes.)	$806.70
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.)	$748.50
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.)	$1,677.60
38256	Temporary transvenous pacemaking electrode, insertion of (Anaes.)	$412.90
38270	Balloon valvuloplasty or isolated atrial septostomy, including cardiac catheterisations before and after balloon dilatation (Assist.) (Anaes.)	$1,556.90
38272	Atrial septal defect closure, with septal occluder or other similar device, by transcatheter approach (Assist.) (Anaes.)	$1,539.70
38275	Myocardial biopsy, by cardiac catheterisation (Anaes.)	$501.30

38285	Implantable ecg loop recorder, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient 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.)	$291.60
38286	Implantable ecg loop recorder, removal of, as an admitted patient in an approved hospital (Anaes.)	$265.00
38287	Ablation of arrhythmia circuit or focus or isolation procedure involving 1 atrial chamber (Assist.) (Anaes.)	$3,534.70
38290	Ablation of arrhythmia circuits or foci, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Assist.) (Anaes.)	$4,498.70
38293	Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (Assist.) (Anaes.)	$4,830.90
38300	Transluminal balloon angioplasty of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$953.40
38303	Transluminal balloon angioplasty of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,187.70
38306	Transluminal stent insertion including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftertransluminal insertion of stent or stents into 1 occlusional site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare care (Assist.) (Anaes.)	$1,371.00
38309	Percutaneous transluminal rotational atherectomy of 1 coronary artery, including balloon angioplasty with no stent insertion where:- no lesion of the coronary artery has been stented; and- each lesion of the coronary artery is complex and heavily calcified; and- balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,462.20
38312	Percutaneous transluminal rotational atherectomy of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where no lesion of the coronary artery has been stented; and each lesion of the coronary artery is complex and heavily calcified; and balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$1,826.50
38315	Percutaneous transluminal rotational atherectomy of more than 1 coronary artery, including balloon angioplasty with no stent insertion where:- no lesion of the coronary arteries has been stented; and- each lesion of the coronary arteries is complex and heavily calcified; and- balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$2,064.40
38318	Percutaneous transluminal rotational atherectomy of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where:- no lesion of the coronary arteries has been stented; and- each lesion of the coronary arteries is complex and heavily calcified; and- balloon angioplasty with or without stenting is not suitable,excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.)	$2,589.10
38350	Single chamber permanent transvenous electrode, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$1,002.00
38353	Permanent cardiac pacemaker, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for	$419.60

	pacemaker implantation (Anaes.)	
38356	Dual chamber permanent transvenous electrodes, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$1,309.30
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Assist.) (Anaes.)	$4,937.60
38359	Pericardium, paracentesis of (excluding aftercare) (Anaes.)	$240.60
38362	Intra-aortic balloon pump, percutaneous insertion of (Anaes.)	$678.40
38365	Permanent cardiac syncronisation device, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (nyha class iii or iv) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a qrs duration greater than or equal to 120ms. (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, for patients who have moderate to severe chronic heart failure (nyha class iii or iv) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a qrs duration greater than or equal to 120ms. Where the service includes right heart catheterisation and any associated venogram of left ventricular veins. Not being a service associated with a service to which items 38200 and 35200 apply (Anaes.)	$2,101.00
38371	Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (nyha class iii or iv) despite optimised medical therapy who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a qrs duration greater than or equal to 120ms. (Anaes.)	$524.80
38384	Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (nyha ii and iii) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. not being a service associated with a service to which item 38213 applies (Assist.) (Anaes.)	$1,810.90
38387	Automatic defibrillator generator, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (nyha ii and iii) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Assist.) (Anaes.)	$527.40
38390	Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Assist.) (Anaes.)	$1,820.10
38393	Automatic defibrillator generator, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Assist.) (Anaes.)	$510.90
38415	Empyema, radical operation for, involving resection of rib (Assist.) (Anaes.)	$730.50

38418	Thoracotomy, exploratory, with or without biopsy (Assist.) (Anaes.)	$1,697.20
38421	Thoracotomy, with pulmonary decortication (Assist.) (Anaes.)	$2,614.00
38424	Thoracotomy, with pleurectomy or pleurodesis, or enucleation of hydatid cysts (Assist.) (Anaes.)	$1,682.60
38427	Thoracoplasty (complete) - 3 or more ribs (Assist.) (Anaes.)	$2,152.60
38430	Thoracoplasty (in stages) each stage (Assist.) (Anaes.)	$1,247.60
38436	Thoracoscopy, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.)	$439.70
38438	Pneumonectomy or lobectomy or segmentectomy not being a service associated with a service to which Item 38418 applies (Assist.) (Anaes.)	$2,683.10
38440	Lung, wedge resection of (Assist.) (Anaes.)	$1,959.20
38441	Radical lobectomy or pneumonectomy including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Assist.) (Anaes.)	$3,306.70
38446	Thoracotomy or sternotomy, for removal of thymus or mediastinal tumour (Assist.) (Anaes.)	$2,069.90
38447	Pericardiectomy via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Assist.) (Anaes.)	$2,744.60
38448	Mediastinum, cervical exploration of, with or without biopsy (Assist.) (Anaes.)	$773.40
38449	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Assist.) (Anaes.)	$3,895.80
38450	Pericardium, transthoracic open surgical drainage of (Assist.) (Anaes.)	$1,556.90
38452	Pericardium, sub-xyphoid drainage of (Assist.) (Anaes.)	$993.20
38453	Tracheal excision and repair without cardiopulmonary bypass (Assist.) (Anaes.)	$3,019.00
38455	Tracheal excision and repair of, with cardiopulmonary bypass (Assist.) (Anaes.)	$3,683.60
38456	Intrathoracic operation on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$2,704.00
38457	Pectus excavatum or pectus carinatum, repair or radical correction of (Assist.) (Anaes.)	$2,532.10
38458	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis (Assist.) (Anaes.)	$1,620.00
38460	Sternal wires or wires, removal of (Anaes.)	$484.00
38462	Sternotomy wound, debridement of, not involving reopening of the mediastinum (Anaes.)	$573.00
38464	Sternotomy wound, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.)	$625.80
38466	Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Assist.) (Anaes.)	$1,690.00
38468	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps or greater omentum (Assist.) (Anaes.)	$2,606.80
38469	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and greater omentum (Assist.) (Anaes.)	$2,723.40
38470	Permanent myocardial electrode, insertion of, by thoracotomy or sternotomy (Assist.) (Anaes.)	$1,761.40
38473	Permanent pacemaker electrode, insertion by open surgical approach (Assist.) (Anaes.)	$975.30

38475	Valve annuloplasty without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Assist.) (Anaes.)	$1,538.60
38477	Valve annuloplasty with insertion of ring not being a service to which item 38478 applies (Assist.) (Anaes.)	$3,706.10
38478	Valve annuloplasty with insertion of ring performed in conjunction with item 38480 or 38481 (Assist.) (Anaes.)	$1,795.00
38480	Valve repair, 1 leaflet (Assist.) (Anaes.)	$3,699.00
38481	Valve repair, 2 or more leaflets (Assist.) (Anaes.)	$4,147.10
38483	Aortic valve leaflet or leaflets, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Assist.) (Anaes.)	$2,723.40
38485	Mitral annulus, reconstruction of, after decalcification, when performed in association with valve surgery (Assist.) (Anaes.)	$1,501.60
38487	Mitral valve, open valvotomy of (Assist.) (Anaes.)	$2,723.40
38488	Valve replacement with bioprosthesis or mechanical prosthesis (Assist.) (Anaes.)	$3,524.80
38489	Valve replacement with allograft (subcoronary or cylindrical implant), or unstented xenograft (Assist.) (Anaes.)	$4,095.90
38490	Sub-valvular structures, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Assist.) (Anaes.)	$1,023.40
38493	Operative management of acute infective endocarditis, in association with heart valve surgery (Assist.) (Anaes.)	$3,437.80
38496	Artery harvesting (other than internal mammary), for coronary artery bypass (Assist.) (Anaes.)	$1,118.70
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 item 38498, 38500, 38501, 38503 or 38504 apply (Assist.) (Anaes.)	$3,662.70
38498	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Assist.) (Anaes.)	$3,588.60
38500	Coronary artery bypass with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Assist.) (Anaes.)	$3,977.30
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 (Assist.) (Anaes.)	$3,812.40
38503	Coronary artery bypass with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Assist.) (Anaes.)	$4,290.70
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	$4,376.70

	performed, either via a median sternotomy or other minimally invasive technique and where a stand- by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Assist.) (Anaes.)	
38505	Coronary endarterectomy, by open operation, including repair with 1 or more patch grafts, each vessel (Assist.) (Anaes.)	$554.00
38506	Left ventricular aneurysm, plication of (Assist.) (Anaes.)	$2,573.60
38507	Left ventricular aneurysm resection with primary repair (Assist.) (Anaes.)	$3,306.60
38508	Left ventricular aneurysm resection with patch reconstruction of the left ventricle (Assist.) (Anaes.)	$4,027.40
38509	Ischaemic ventricular septal rupture, repair of (Assist.) (Anaes.)	$4,073.40
38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Assist.) (Anaes.)	$3,599.70
38515	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Assist.) (Anaes.)	$4,604.90
38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy (Assist.) (Anaes.)	$4,892.50
38550	Ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Assist.) (Anaes.)	$3,480.70
38553	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Assist.) (Anaes.)	$4,692.30
38556	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Assist.) (Anaes.)	$5,274.10
38559	Aortic arch and ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Assist.) (Anaes.)	$4,522.40
38562	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Assist.) (Anaes.)	$5,594.90
38565	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Assist.) (Anaes.)	$6,285.30
38568	Descending thoracic aorta, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endvascular means (Assist.) (Anaes.)	$3,226.10
38571	Descending thoracic aorta, repair or replacement of, using shunt or cardiopulmonary bypass (Assist.) (Anaes.)	$3,304.20
38572	Operative management of acute rupture or dissection, in conjunction with procedures on the thoracic aorta (Assist.) (Anaes.)	$3,595.50
38577	Cannulation for, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.)	$1,030.90
38588	Cannulation of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.)	$867.30
38600	Central cannulation for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Assist.) (Anaes.)	$2,613.80
38603	Peripheral cannulation for cardiopulmonary bypass excluding post- operative management (Assist.) (Anaes.)	$1,731.60
38609	Intra-aortic balloon pump, insertion of, by arteriotomy (Assist.) (Anaes.)	$875.50
38612	Intra-aortic balloon pump, removal of, with closure of artery by direct suture (Assist.) (Anaes.)	$849.90

38613	Intra-aortic balloon pump, removal of, with closure of artery by patch graft (Assist.) (Anaes.)	$1,066.70
38615	Left or right ventricular assist device, insertion of (Assist.) (Anaes.)	$2,613.80
38618	Left and right ventricular assist device, insertion of (Assist.) (Anaes.)	$3,254.30
38621	Left or right ventricular assist device, removal of, as an independent procedure (Assist.) (Anaes.)	$1,292.40
38624	Left and right ventricular assist device, removal of, as an independent procedure (Assist.) (Anaes.)	$1,459.50
38627	Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation, in patients supported by these devices (Assist.) (Anaes.)	$1,353.60
38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Assist.) (Anaes.)	$947.00
38640	Re-operation via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Assist.) (Anaes.)	$1,677.60
38643	Thoracotomy or sternotomy involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Assist.) (Anaes.)	$1,875.60
38647	Thoracotomy or sternotomy involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Assist.) (Anaes.)	$3,730.20
38650	Myomectomy or myotomy for hypertrophic obstructive cardiomyopathy (Assist.) (Anaes.)	$3,470.50
38653	Open heart surgery, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$3,436.20
38654	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (nyha class iii or iv) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a qrs duration greater than or equal to 120ms. (Assist.) (Anaes.)	$2,113.80
38656	Thoracotomy or median sternotomy for post-operative bleeding (Assist.) (Anaes.)	$1,646.00
38670	Cardiac tumour, excision of, involving the wall of the artrium or inter-atrial septum, without patch or conduit reconstruction (Assist.) (Anaes.)	$3,215.40
38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Assist.) (Anaes.)	$4,158.20
38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of (Assist.) (Anaes.)	$3,514.20
38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Assist.) (Anaes.)	$4,168.50
38700	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$1,824.70
38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,284.20
38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,105.10
38709	Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,642.10

38712	Aortic interruption, repair of, for congenital heart disease (Assist.) (Anaes.)	$4,533.50
38715	Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$2,700.20
38718	Main pulmonary artery, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,758.50
38721	Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$2,614.40
38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,642.10
38727	Intrathoracic vessels, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Assist.) (Anaes.)	$2,555.00
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 (Assist.) (Anaes.)	$3,642.10
38733	Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$2,367.00
38736	Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,378.00
38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.)	$3,045.00
38742	Atrial septal defect, closure by open exposure direct suture or patch, for congenital heart disease (Assist.) (Anaes.)	$3,378.00
38745	Intra-atrial baffle, insertion of, for congenital heart disease (Assist.) (Anaes.)	$3,906.00
38748	Ventricular septectomy, for congenital heart disease (Assist.) (Anaes.)	$4,405.00
38751	Ventricular septal defect, closure by direct suture or patch, for congenital heart disease (Assist.) (Anaes.)	$3,679.40
38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease (Assist.) (Anaes.)	$4,228.60
38757	Extracardiac conduit, insertion of, for congenital heart disease (Assist.) (Anaes.)	$4,405.00
38760	Extracardiac conduit, replacement of, for congenital heart disease (Assist.) (Anaes.)	$3,378.00
38763	Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease (Assist.) (Anaes.)	$3,895.90
38766	Ventricular augmentation, right or left, for congenital heart disease (Assist.) (Anaes.)	$3,912.60
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	$131.10
38806	Intercostal drain, insertion of, not involving resection of rib (excluding aftercare) (Anaes.)	$240.60
38809	Intercostal drain, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.)	$292.10
38812	Percutaneous needle biopsy of lung (Anaes.)	$378.00

Neurosurgical

39000	Lumbar puncture (Anaes.)	$172.80
39003	Cisternal puncture (Anaes.)	$174.10

39006	Ventricular puncture (not including burr-hole) (Anaes.)	$405.00
39009	Subdural haemorrhage, tap for, each tap (Anaes.)	$114.90
39012	Burr-hole, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.)	$435.60
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.)	$193.40
39015	Ventricular reservoir, external ventricular drain or intracranial pressure monitoring device, insertion of - including burr-hole (excluding after-care) (Assist.) (Anaes.)	$709.60
39018	Cerebrospinal fluid reservoir, insertion of (Assist.) (Anaes.)	$660.70
39100	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	$376.00
39106	Neurectomy, intracranial, for trigeminal neuralgia (Assist.) (Anaes.)	$1,880.40
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol (Anaes.)	$1,022.10
39112	Cranial nerve, intracranial decompression of, using microsurgical techniques (Assist.) (Anaes.)	$3,093.40
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 (Assist.) (Anaes.)	$548.70
39121	Percutaneous cordotomy (Assist.) (Anaes.)	$999.70
39124	Cordotomy or myelotomy, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Assist.) (Anaes.)	$3,775.00
39125	Intrathecal or epidural spinal catheter insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Assist.) (Anaes.)	$659.40
39126	Infusion pump, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Assist.) (Anaes.)	$656.20
39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic intractable pain (Anaes.)	$1,084.00
39128	Infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Assist.) (Anaes.)	$1,202.20
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.)	$1,198.80
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	$208.90
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.)	$289.40
39134	Neurostimulator or receiver, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the	$634.20

	management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Assist.) (Anaes.)	
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.)	$286.60
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.)	$289.40
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.)	$1,021.90
39138	Peripheral nerve lead, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Assist.) (Anaes.)	$1,246.70
39139	Epidural electrode for management of pain, insertion of 1 or more of by partial or total laminectomy, including implantation of pulse generator (1 or 2 stages) (Assist.) (Anaes.)	$1,961.90
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)	$531.40
39300	Cutaneous nerve (including digital nerve), primary repair of, using microsurgical techniques (Assist.) (Anaes.)	$665.80
39303	Cutaneous nerve (including digital nerve), secondary repair of, using microsurgical techniques (Assist.) (Anaes.)	$929.90
39306	Nerve trunk, primary repair of, using microsurgical techniques (Assist.) (Anaes.)	$1,230.10
39309	Nerve trunk, secondary repair of, using microsurgical techniques (Assist.) (Anaes.)	$1,568.70
39312	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Assist.) (Anaes.)	$815.30
39315	Nerve trunk, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Assist.) (Anaes.)	$1,946.70
39318	Cutaneous nerve (including digital nerve), nerve graft to, using microsurgical techniques (Assist.) (Anaes.)	$1,308.70
39321	Nerve, transposition of (Assist.) (Anaes.)	$950.10
39323	Percutaneous neurotomy by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Assist.) (Anaes.)	$508.10
39324	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve, by open operation (Assist.) (Anaes.)	$511.40
39327	Neurectomy, neurotomy or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Assist.) (Anaes.)	$946.10
39330	Neurolysis by open operation without transposition, not being a service associated with a service to which item 39312 applies (Assist.) (Anaes.)	$583.00
39331	Carpal tunnel release (division of transverse carpal ligament), by any method (Anaes.)	$602.60
39333	Brachial plexus, exploration of, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$735.10
39500	Vestibular nerve, section of, via posterior fossa (Assist.) (Anaes.)	$3,270.00
39503	Facio-hypoglossal nerve or facio- accessory nerve, anastomosis of (Assist.) (Anaes.)	$1,733.40

39600	Intracranial haemorrhage, burr-hole craniotomy for - including burr-holes (Assist.) (Anaes.)	$917.00
39603	Intracranial haemorrhage, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Assist.) (Anaes.)	$2,162.50
39606	Fractured skull, depressed or comminuted, operation for (Assist.) (Anaes.)	$1,443.90
39609	Fractured skull, compound, without dural penetration, operation for (Assist.) (Anaes.)	$1,775.40
39612	Fractured skull, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Assist.) (Anaes.)	$2,270.10
39615	Fractured skull with rhinorrhoea or otorrhoea, cranioplasty and repair of (Assist.) (Anaes.)	$2,162.50
39640	Tumour involving anterior cranial fossa, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Assist.) (Anaes.)	$5,947.20
39642	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension, (intracranial procedure) (Assist.) (Anaes.)	$6,532.20
39646	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Assist.) (Anaes.)	$6,920.10
39650	Tumour involving middle cranial fossa and infra-temporal fossa, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Assist.) (Anaes.)	$6,810.00
39653	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Assist.) (Anaes.)	$9,593.90
39654	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Assist.) (Anaes.)	$6,187.30
39656	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, co- surgeon (Assist.)	$6,600.00
39658	Tumour involving the clivus, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Assist.) (Anaes.)	$5,480.60
39660	Tumour or vascular lesion of cavernous sinus, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Assist.) (Anaes.)	$5,906.30
39662	Tumour or vascular lesion of foramen magnum, radical excision of, via transcondylar or far lateral suboccipital approach (Assist.) (Anaes.)	$5,480.60
39700	Skull tumour, benign or malignant, excision of, excluding cranioplasty (Assist.) (Anaes.)	$1,232.00
39703	Intracranial tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Assist.) (Anaes.)	$1,100.90
39706	Intracranial tumour, biopsy or decompression of via osteoplastic flap or biopsy and decompression of via osteoplastic flap (Assist.) (Anaes.)	$2,320.90
39709	Craniotomy for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$3,088.70
39712	Craniotomy for removal of meningioma, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.)	$5,217.30
39715	Pituitary tumour, removal of, by transcranial or transphenoidal approach (Assist.) (Anaes.)	$3,958.70

39718	Arachnoidal cyst, craniotomy for (Assist.) (Anaes.)	$1,918.60
39721	Craniotomy, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Assist.) (Anaes.)	$1,443.90
39800	Aneurysm, clipping or reinforcement of sac (Assist.) (Anaes.)	$5,233.20
39803	Intracranial arteriovenous malformation, excision of (Assist.) (Anaes.)	$5,245.50
39806	Aneurysm, or arteriovenous malformation, intracranial proximal artery clipping of (Assist.) (Anaes.)	$2,596.90
39812	Intracranial aneurysm or arteriovenous fistula, ligation of cervical vessel or vessels (Assist.) (Anaes.)	$1,260.10
39815	Carotid-cavernous fistula, obliteration of - combined cervical and intracranial procedure (Assist.) (Anaes.)	$2,891.70
39818	Extracranial to intracranial bypass using superficial temporal artery (Assist.) (Anaes.)	$3,946.50
39821	Extracranial to intracranial bypass using saphenous vein graft (Assist.) (Anaes.)	$3,976.00
39900	Intracranial infection, drainage of, via burr-hole - including burr-hole (Assist.) (Anaes.)	$953.90
39903	Intracranial abscess, excision of (Assist.) (Anaes.)	$2,887.80
39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for (Assist.) (Anaes.)	$1,443.90
40000	Ventriculo-cisternostomy (Torkildsen's operation) (Assist.) (Anaes.)	$1,451.80
40003	Cranial or cisternal shunt diversion, insertion of (Assist.) (Anaes.)	$1,704.90
40006	Lumbar shunt diversion, insertion of (Assist.) (Anaes.)	$1,243.30
40009	Cranial, cisternal or lumbar shunt, revision or removal of (Assist.) (Anaes.)	$969.90
40012	Third ventriculostomy (open or endoscopic) with or without endoscopic septum pellucidotomy (Assist.) (Anaes.)	$1,878.20
40015	Subtemporal decompression (Assist.) (Anaes.)	$1,156.30
40018	Lumbar cerebrospinal fluid drain, insertion of (Anaes.)	$289.40
40100	Meningocele, excision and closure of (Assist.) (Anaes.)	$1,324.50
40103	Myelomeningocele, excision and closure of, including skin flaps or Z plasty where performed (Assist.) (Anaes.)	$1,606.60
40106	Arnold-Chiari malformation, decompression of (Assist.) (Anaes.)	$2,655.00
40109	Encephalocoele, excision and closure of (Assist.) (Anaes.)	$2,855.00
40112	Tethered cord, release of, including lipomeningocele or diastematomyelia (Assist.) (Anaes.)	$2,794.20
40115	Craniostenosis, operation for - single suture (Assist.) (Anaes.)	$1,142.40
40118	Craniostenosis, operation for - more than 1 suture (Assist.) (Anaes.)	$1,511.30
40300	Intervertebral disc or discs, partial or total laminectomy for removal of (Assist.) (Anaes.)	$2,040.00
40301	Intervertebral disc or discs, microsurgical discectomy of (Assist.) (Anaes.)	$2,050.00
40303	Recurrent disc lesion or spinal stenosis, or both, partial or total laminectomy for - 1 level (Assist.) (Anaes.)	$2,125.00
40306	Spinal stenosis, partial or total laminectomy for, involving more than 1 vertebral interspace (disc level) (Assist.) (Anaes.)	$3,006.20
40309	Extradural tumour or abscess, partial or total laminectomy for (Assist.) (Anaes.)	$2,241.80
40312	Intradural lesion, partial or total laminectomy for, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$2,799.20

40315	Craniocervical junction lesion, transoral approach for (Assist.) (Anaes.)	$2,511.10
40316	Odontoid screw fixation (Assist.) (Anaes.)	$4,754.80
40318	Intramedullary tumour or arteriovenous malformation, partial or total laminectomy and radical excision of (Assist.) (Anaes.)	$4,467.20
40321	Posterior spinal fusion, not being a service to which items 40324 and 40327 apply (Assist.) (Anaes.)	$2,177.40
40324	Partial or total laminectomy followed by posterior fusion, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (Assist.) (Anaes.)	$1,630.00
40327	Partial or total laminectomy followed by posterior fusion, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare (Assist.)	$1,011.60
40330	Spinal rhizolysis involving exposure of spinal nerve roots - for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels - with or without partial or total laminectomy (Assist.) (Anaes.)	$2,313.90
40331	Cervical decompression of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Assist.) (Anaes.)	$1,879.80
40332	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Assist.) (Anaes.)	$2,898.50
40333	Cervical partial or total discectomy (anterior), without fusion (Assist.) (Anaes.)	$2,040.00
40334	Cervical decompression of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Assist.) (Anaes.)	$2,715.00
40335	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Assist.) (Anaes.)	$3,687.00
40336	Intradiscal injection of chymopapain (discase) - 1 disc (Assist.) (Anaes.)	$499.80
40339	Hydromyelia, plugging of obex for, with or without duroplasty (Assist.) (Anaes.)	$3,064.70
40342	Hydromyelia, craniotomy and partial or total laminectomy for, with cavity packing and csf shunt (Assist.) (Anaes.)	$3,775.00
40345	Thoracic decompression of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Assist.) (Anaes.)	$3,305.30
40348	Thoracic decompression of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Assist.) (Anaes.)	$3,202.90
40351	Thoraco-lumbar or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Assist.) (Anaes.)	$3,262.10
40600	Cranioplasty, reconstructive (Assist.) (Anaes.)	$2,063.70
40700	Corpus callosum, anterior section of, for epilepsy (Assist.) (Anaes.)	$4,459.10
40703	Corticectomy, topectomy or partial lobectomy for epilepsy (Assist.) (Anaes.)	$2,909.70
40706	Hemispherectomy for intractable epilepsy (Assist.) (Anaes.)	$3,391.70
40709	Burr-hole placement of intracranial depth or surface electrodes (Assist.) (Anaes.)	$1,320.00
40712	Intracranial electrode placement via craniotomy (Assist.) (Anaes.)	$2,680.00
40800	Stereotactic anatomical localisation, as an independent procedure (Assist.) (Anaes.)	$1,458.10
40801	Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep	$4,480.00

	white matter tracts, not being a service associated with deep brain stimulation for parkinson's disease, essential tremor or dystonia (Assist.) (Anaes.)	
40803	Intracranial stereotactic procedure by any method, not being a service to which item 40800 or 40801 applies (Assist.) (Anaes.)	$2,334.40
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; oressential tremor or dystonia where the patient's symptoms cause severe disability (Assist.) (Anaes.)	$3,872.10
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; oressential tremor or dystonia where the patient's symptoms cause severe disability. (Assist.) (Anaes.)	$10,125.00
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; oressential tremor or dystonia where the patient's symptoms cause severe disability. (Assist.) (Anaes.)	$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; oressential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$828.70
40856	Deep brain stimulation (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; oressential 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 lead for the treatment of: parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; oressential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$1,328.80
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; oressential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$4,174.10
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; oressential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$298.70
40903	Neuroendoscopy, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Assist.) (Anaes.)	$1,425.00
40905	Craniotomy, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.)	$952.20
	Ear, nose and throat	
41500	Ear, foreign body (other than ventilating tube) in, removal of, other than by simple	$130.50

	syringing (Anaes.)	
41503	Ear, removal of foreign body in, involving incision of external auditory canal (Anaes.)	$438.40
41506	Aural polyp, removal of (Anaes.)	$265.10
41509	External auditory meatus, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)	$257.80
41512	Meatoplasty involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Assist.) (Anaes.)	$1,113.20
41515	Meatoplasty involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41560 or 41563 applies (Assist.) (Anaes.)	$779.60
41518	External auditory meatus, removal of exostoses in (Assist.) (Anaes.)	$1,920.00
41521	Correction of auditory canal stenosis, including meatoplasty, with or without grafting (Assist.) (Anaes.)	$2,020.00
41524	Reconstruction of external auditory canal, being a service associated with a service to which items 41557, 41560 and 41563 apply (Assist.) (Anaes.)	$585.00
41527	Myringoplasty, transcanal approach (Rosen incision) (Assist.) (Anaes.)	$1,094.80
41530	Myringoplasty, postaural or endaural approach with or without mastoid inspection (Anaes.)	$1,821.30
41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty (Assist.) (Anaes.)	$2,091.20
41536	Atticotomy with reconstruction of the bony defect with or without myringoplasty (Assist.) (Anaes.)	$2,378.00
41539	Ossicular chain reconstruction (Assist.) (Anaes.)	$1,979.80
41542	Ossicular chain reconstruction and myringoplasty (Assist.) (Anaes.)	$2,147.90
41545	Mastoidectomy (cortical) (Assist.) (Anaes.)	$993.80
41548	Obliteration of the mastoid cavity (Assist.) (Anaes.)	$1,325.00
41551	Mastoidectomy, intact wall technique, with myringoplasty (Assist.) (Anaes.)	$3,062.50
41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction (Assist.) (Anaes.)	$3,807.60
41557	Mastoidectomy (radical or modified radical) (Assist.) (Anaes.)	$2,140.00
41560	Mastoidectomy (radical or modified radical) and myringoplasty (Anaes.)	$2,317.70
41563	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction (Assist.) (Anaes.)	$2,960.00
41564	Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube (Assist.) (Anaes.)	$3,702.00
41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty (Assist.) (Anaes.)	$2,012.10
41569	Decompression of facial nerve in its mastoid portion (Assist.) (Anaes.)	$2,182.40
41572	Labyrinthotomy or destruction of labyrinth (Assist.) (Anaes.)	$1,773.10
41575	Cerebellopontine angle tumour, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Assist.) (Anaes.)	$4,706.70
41576	Cerebello - pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid appoach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Assist.) (Anaes.)	$6,620.80

41578	Cerebello pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$4,845.00
41579	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co- surgeon (Assist.)	$3,635.00
41581	Tumour involving infra-temporal fossa, removal of, involving craniotomy and radical excision of (Assist.) (Anaes.)	$5,272.80
41584	Partial temporal bone resection for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Assist.) (Anaes.)	$3,817.30
41587	Total temporal bone resection for removal of tumour (Assist.) (Anaes.)	$4,777.80
41590	Endolymphatic sac, transmastoid decompression with or without drainage of (Assist.) (Anaes.)	$2,345.00
41593	Translabyrinthine vestibular nerve section (Assist.) (Anaes.)	$2,463.30
41596	Retrolabyrinthine vestibular nerve section or cochlear nerve section, or both (Assist.) (Anaes.)	$3,465.00
41599	Internal auditory meatus, exploration by middle cranial fossa approach with cranial nerve decompression (Assist.) (Anaes.)	$3,465.00
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.)	$1,260.00
41604	Osseo-integration procedure - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)	$470.00
41608	Stapedectomy (Assist.) (Anaes.)	$2,140.00
41611	Stapes mobilisation (Assist.) (Anaes.)	$1,262.90
41614	Round window surgery including repair of cochleotomy (Assist.) (Anaes.)	$2,050.00
41615	Oval window surgery, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Assist.) (Anaes.)	$2,006.10
41617	Cochlear implant, insertion of, including mastoidectomy (Assist.) (Anaes.)	$3,525.10
41620	Glomus tumour, transtympanic removal of (Assist.) (Anaes.)	$1,504.90
41623	Glomus tumour, transmastoid removal of, including mastoidectomy (Assist.) (Anaes.)	$1,936.30
41626	Abscess or inflammation of middle ear, operation for (excluding aftercare) (Anaes.)	$262.00
41629	Middle ear, exploration of (Assist.) (Anaes.)	$995.00
41632	Middle ear, insertion of tube for drainage of (including myringotomy) (Anaes.)	$431.90
41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, 1 or more, with or without myringoplasty (Assist.) (Anaes.)	$2,068.40
41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Assist.) (Anaes.)	$2,700.40
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.)	$259.80
41647	Ear toilet requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.)	$174.00
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.)	$223.50
41659	Nose, removal of foreign body in, other than by simple probing (Anaes.)	$131.10
41662	Nasal polyp or polypi (simple), removal of	$163.40
41665	Nasal polyp or polypi (requiring admission to hospital), removal of (Anaes.)	$485.00
41668	Nasal polyp or polypi (requiring admission to hospital), removal of (Anaes.)	$478.20
41671	Nasal septum, septoplasty, submucous resection or closure of septal perforation (Anaes.)	$970.00
41672	Nasal septum, reconstruction of (Assist.) (Anaes.)	$1,245.00
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum, turbinates or pharynx - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)	$207.30
41677	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$158.90
41680	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	$257.80
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.)	$199.00
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
41695	Nasal turbinates, cryotherapy to (Anaes.)	$170.30
41698	Maxillary antrum, proof puncture and lavage of (Anaes.)	$61.80
41701	Maxillary antrum, proof puncture and lavage of under general anaesthesia (requiring admission to hospital), not being a service associated with a service to which another item in this Group applies (Anaes.)	$189.70
41704	Maxillary antrum, lavage of each attendance at which the procedure is performed, including any associated consultation (Anaes.)	$62.40
41707	Maxillary artery, transantral ligation of (Assist.) (Anaes.)	$827.10
41710	Antrostomy (radical) (Assist.) (Anaes.)	$1,062.60
41713	Antrostomy (radical) with transantral ethmoidectomy or transantral vidian neurectomy (Assist.) (Anaes.)	$1,104.90
41716	Antrum, intranasal operation on or removal of foreign body from (Assist.) (Anaes.)	$560.00
41719	Antrum, drainage of, through tooth socket (Anaes.)	$240.00

41722	Oroantral fistula, plastic closure of (Assist.) (Anaes.)	$998.20
41725	Ethmoidal artery or arteries, transorbital ligation of (unilateral) (Assist.) (Anaes.)	$843.20
41728	Lateral rhinotomy with removal of tumour (Assist.) (Anaes.)	$1,730.60
41729	Dermoid of nose, excision of, with intranasal extension (Assist.) (Anaes.)	$1,045.70
41731	Frontonasal ethmoidectomy by external approach with or without sphenoidectomy (Assist.) (Anaes.)	$1,609.80
41734	Radical frontoethmoidectomy with osteoplastic flap (Assist.) (Anaes.)	$1,836.10
41737	Frontal sinus, or ethmoidal sinuses on the one side, intranasal operation on (Assist.) (Anaes.)	$920.00
41740	Frontal sinus, catheterisation of (Anaes.)	$122.00
41743	Frontal sinus, trephine of (Assist.) (Anaes.)	$624.50
41746	Frontal sinus, radical obliteration of (Assist.) (Anaes.)	$1,321.30
41749	Ethmoidal sinuses, external operation on (Assist.) (Anaes.)	$1,109.50
41752	Sphenoidal sinus, intranasal operation on (Assist.) (Anaes.)	$562.20
41755	Eustachian tube, catheterisation of (Anaes.)	$74.50
41758	Division of pharyngeal adhesions (Anaes.)	$186.10
41761	Post nasal space, direct examination of, with or without biopsy (Anaes.)	$226.30
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination (Anaes.)	$203.60
41767	Nasopharyngeal angiofibroma, removal of (Assist.) (Anaes.)	$1,166.30
41770	Pharyngeal pouch, removal of, with or without cricopharyngeal myotomy (Assist.) (Anaes.)	$1,430.00
41773	Pharyngeal pouch, endoscopic resection of (Dohlman's operation) (Assist.) (Anaes.)	$1,149.90
41776	Cricopharyngeal myotomy with or without inversion of pharyngeal pouch (Assist.) (Anaes.)	$1,184.80
41779	Pharyngotomy (lateral), with or without total excision of tongue (Assist.) (Anaes.)	$1,109.80
41782	Partial pharyngectomy via pharyngotomy (Assist.) (Anaes.)	$1,912.40
41785	Partial pharyngectomy via pharyngotomy with partial or total glossectomy (Assist.) (Anaes.)	$2,410.00
41786	Uvulopalatopharyngoplasty, with or without tonsillectomy, by any means (Assist.) (Anaes.)	$1,488.30
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 (Assist.) (Anaes.)	$1,141.00
41788	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (Anaes.)	$346.50
41789	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (Anaes.)	$465.50
41792	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (Anaes.)	$755.00
41793	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (Anaes.)	$755.00
41796	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (Anaes.)	$310.50
41797	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (Anaes.)	$265.10
41800	Adenoids, removal of (Anaes.)	$320.00
41801	Adenoids, removal of (Anaes.)	$320.00

41804	Lingual tonsil or lateral pharyngeal bands, removal of (Anaes.)	$178.00
41807	Peritonsillar abscess (quinsy), incision of (Anaes.)	$130.70
41810	Uvulotomy or uvulectomy (Anaes.)	$71.00
41813	Vallecular or pharyngeal cysts, removal of (Assist.) (Anaes.)	$649.20
41816	Oesophagoscopy (with rigid oesophagoscope) (Anaes.)	$348.20
41819	Dilatation of stricture of upper gastro-intestinal tract using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.)	$618.80
41820	Dilatation of stricture of upper gastro-intestinal tract using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes.)	$772.80
41822	Oesophagoscopy (with rigid oesophagoscope) with biopsy (Anaes.)	$440.00
41825	Oesophagoscopy (with rigid oesophagoscope) with removal of foreign body (Assist.) (Anaes.)	$657.30
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	$92.40
41831	Oesophagus, endoscopic pneumatic dilatation of (Assist.) (Anaes.)	$658.30
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (Anaes.)	$359.70
41834	Laryngectomy (total) (Assist.) (Anaes.)	$2,330.50
41837	Vertical hemilaryngectomy including tracheostomy (Assist.) (Anaes.)	$2,160.20
41840	Supraglottic laryngectomy including tracheostomy (Assist.) (Anaes.)	$2,737.80
41843	Laryngopharyngectomy or primary restoration of alimentary continuity after laryngopharyngectomy using stomach or bowel (Assist.) (Anaes.)	$2,532.60
41846	Larynx, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.)	$297.00
41849	Larynx, direct examination of, with biopsy (Assist.) (Anaes.)	$518.80
41852	Larynx, direct examination of, with removal of tumour (Assist.) (Anaes.)	$645.00
41855	Microlaryngoscopy (Assist.) (Anaes.)	$636.20
41858	Microlaryngoscopy with removal of juvenile papillomata (Assist.) (Anaes.)	$897.90
41861	Microlaryngoscopy with removal of benign lesions of the larynx by laser surgery (Assist.) (Anaes.)	$1,235.00
41864	Microlaryngoscopy with removal of tumour (Assist.) (Anaes.)	$812.00
41867	Microlaryngoscopy with arytenoidectomy (Assist.) (Anaes.)	$1,141.20
41868	Laryngeal web, division of, using microlarygoscopic techniques (Anaes.)	$710.20
41870	Injection of vocal cord by teflon, fat, collagen or gelfoam (Assist.) (Anaes.)	$910.00
41873	Larynx, fractured, operation for (Assist.) (Anaes.)	$1,049.90
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (Assist.) (Anaes.)	$1,177.40
41879	Laryngoplasty or tracheoplasty, including tracheostomy (Assist.) (Anaes.)	$1,937.10
41880	Tracheostomy by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.)	$470.20
41881	Tracheostomy by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Assist.) (Anaes.)	$768.00

41884	Cricothyrostomy by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	$165.00
41885	Trache-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Assist.) (Anaes.)	$487.10
41886	Trachea, removal of foreign body in (Anaes.)	$297.80
41889	Bronchoscopy, as an independent procedure (Anaes.)	$297.80
41892	Bronchoscopy with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.)	$402.60
41895	Bronchus, removal of foreign body in (Assist.) (Anaes.)	$627.30
41898	Fibreoptic bronchoscopy with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Assist.) (Anaes.)	$439.70
41901	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (Assist.) (Anaes.)	$1,064.00
41904	Bronchoscopy with dilatation of tracheal stricture (Anaes.)	$442.70
41905	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Assist.) (Anaes.)	$730.90
41907	Nasal septum button, insertion of (Anaes.)	$227.50
41910	Duct of major salivary gland, transposition of (Assist.) (Anaes.)	$712.40
	Ophthalmology	
42503	Ophthalmological examination under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)	$235.00
42506	Eye, enucleation of, with or without sphere implant (Assist.) (Anaes.)	$886.50
42509	Eye, enucleation of, with insertion of integrated implant (Assist.) (Anaes.)	$1,325.00
42510	Eye, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Assist.) (Anaes.)	$1,480.00
42512	Globe, evisceration of (Assist.) (Anaes.)	$761.50
42515	Globe, evisceration of, and insertion of intrascleral ball or cartilage (Assist.) (Anaes.)	$1,094.40
42518	Anophthalmic orbit, insertion of cartilage or artificial implant as a delayed procedure, or removal of implant from socket; or placement of a motility intergrating peg by drilling into existing orbital implant (Assist.) (Anaes.)	$625.80
42521	Anophthalmic socket, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Assist.) (Anaes.)	$2,003.50
42524	Orbit, skin graft to, as a delayed procedure (Anaes.)	$378.00
42527	Contracted socket, reconstruction including mucous membrane grafting and stent mould (Assist.) (Anaes.)	$735.10
42530	Orbit, exploration with or without biopsy, requiring removal of bone (Assist.) (Anaes.)	$1,325.00
42533	Orbit, exploration of, with drainage or biopsy not requiring removal of bone (Assist.) (Anaes.)	$778.40
42536	Orbit, exenteration of, with or without skin graft and with or without temporalis muscle transplant (Assist.) (Anaes.)	$1,521.90
42539	Orbit, exploration of, with removal of tumour or foreign body, requiring removal of bone (Assist.) (Anaes.)	$2,672.90

42542	Orbit, exploration of anterior aspect with removal of tumour or foreign body (Assist.) (Anaes.)	$923.10
42543	Orbit, exploration of retrobulbar aspect with removal of tumour or foreign body (Assist.) (Anaes.)	$1,612.90
42545	Orbit, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Assist.) (Anaes.)	$2,515.00
42548	Optic nerve meninges, incision of (Assist.) (Anaes.)	$1,671.40
42551	Eye, penetrating wound or rupture of, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Assist.) (Anaes.)	$1,157.80
42554	Eye, penetrating wound or rupture of, with incarceration or prolapse of uveal tissue repair (Assist.) (Anaes.)	$1,360.90
42557	Penetrating wound or rupture of, with incarceration of lens or vitreous repair (Assist.) (Anaes.)	$1,892.80
42563	Intraocular foreign body, removal from anterior segment (Assist.) (Anaes.)	$1,040.80
42569	Intraocular foreign body, removal from posterior segment (Assist.) (Anaes.)	$1,892.80
42572	Orbital abscess or cyst, drainage of (Anaes.)	$184.80
42573	Dermoid, periorbital, excision of (Anaes.)	$417.60
42574	Dermoid, orbital, excision of (Assist.) (Anaes.)	$840.10
42575	Tarsal cyst, extirpation of (Anaes.)	$151.90
42581	Ectropion or entropion, tarsal cauterisation of (Anaes.)	$193.40
42584	Tarsorrhaphy (Assist.) (Anaes.)	$521.40
42587	Trichiasis, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.)	$86.30
42590	Canthoplasty, medial or lateral (Assist.) (Anaes.)	$755.00
42593	Lacrimal gland, excision of palpebral lobe (Anaes.)	$323.80
42596	Lacrimal sac, excision of, or operation on (Assist.) (Anaes.)	$930.80
42599	Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Assist.) (Anaes.)	$1,095.40
42602	Lacrimal canalicular system, establishment of patency by open operation, 1 eye (Assist.) (Anaes.)	$1,157.50
42605	Lacrimal canaliculus, immediate repair of (Assist.) (Anaes.)	$929.70
42608	Lacrimal drainage by insertion of glass tube, as an independent procedure (Assist.) (Anaes.)	$507.00
42610	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.)	$167.70
42611	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.)	$264.70
42614	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare)	$88.10
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	$126.00

	(excluding aftercare)	
42617	Punctum snip operation (Anaes.)	$208.80
42620	Punctum, occlusion of, by use of a plug (Anaes.)	$121.70
42621	Punctum, temporary occlusion of, by use of electrical cautery (Anaes.)	$92.40
42622	Punctum, permanent occlusion of, by use of electrical cautery (Anaes.)	$144.70
42623	Dacryocystorhinostomy (Assist.) (Anaes.)	$1,498.40
42626	Dacryocystorhinostomy where a previous dacryocystorhinostomy has been performed (Assist.) (Anaes.)	$1,936.00
42629	Conjunctivorhinostomy including dacryocystorhinostomy and fashioning of conjunctival flaps (Assist.) (Anaes.)	$1,651.80
42632	Conjunctival peritomy or repair of corneal laceration by conjunctival flap (Anaes.)	$209.10
42635	Corneal perforations, sealing of, with tissue adhesive (Assist.) (Anaes.)	$550.90
42638	Conjunctival graft over cornea (Assist.) (Anaes.)	$713.20
42641	Autoconjunctival transplant, or mucous membrane graft (Assist.) (Anaes.)	$905.00
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.)	$117.40
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.)	$132.30
42651	Cornea, epithelial debridement for eliminating band keratopathy (Anaes.)	$289.40
42653	Cornea, transplantation of, full thickness (Assist.) (Anaes.)	$2,715.70
42656	Cornea, transplantation of, second and subsequent procedures (Assist.) (Anaes.)	$3,021.20
42659	Cornea, transplantation of, superficial or lamellar (Assist.) (Anaes.)	$1,685.00
42662	Sclera, transplantation of, full thickness, including collection of donor material (Assist.) (Anaes.)	$1,598.80
42665	Sclera, transplantation of, superficial or lamellar, including collection of donor material (Assist.) (Anaes.)	$1,090.00
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	$226.20
42668	Corneal sutures, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.)	$133.90
42672	Corneal incisons, to correct corneal astigmatism of more than 11/2 dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Assist.) (Anaes.)	$1,522.90
42673	Additional corneal incisions, to correct corneal astigmatism of more than 11/2 dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Assist.) (Anaes.)	$915.00
42676	Conjunctiva, biopsy of, as an independent procedure	$206.10
42677	Conjunctiva, cautery of, including treatment of pannus each attendance at which treatment is given including any associated consultation (Anaes.)	$118.00
42680	Conjunctiva, cryotherapy to, for melanotic lesions or similar using CO2 or 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.)	$213.20
42692	Limbic tumour, removal of, excluding Pterygium (Assist.) (Anaes.)	$508.10
42695	Limbic tumour, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Assist.) (Anaes.)	$810.50
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.)	$1,569.50
42701	Intraocular lens, insertion of, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$1,098.50
42702	Lens extraction and insertion of artificial lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$2,206.80
42703	Intraocular lens or iris prosthesis insertion of, into the posterior chamber with fixation to the iris or sclera (Assist.) (Anaes.)	$1,070.00
42704	Intraocular lens, removal or repositioning of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.)	$731.40
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.)	$1,308.20
42710	Intraocular lens, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Assist.) (Anaes.)	$1,340.50
42713	Iris suturing, mccannell technique or similar, for fixation of intraocular lens or repair of iris defect (Assist.) (Anaes.)	$658.90
42716	Cataract, juvenile, removal of, including subsequent needlings (Assist.) (Anaes.)	$2,600.00
42719	Capsulectomy or removal of vitreous, or both, via the anterior chamber by any method, not being a service associated with a service to which item 42698, 42702 or 42716 applies (Assist.) (Anaes.)	$946.50
42725	Vitrectomy via pars plana sclerotomies including the removal of vitreous, division of bands or removal of epiretinal membranes (Assist.) (Anaes.)	$2,463.70
42731	Limbal or pars plana lensectomy combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Assist.) (Anaes.)	$2,631.90
42734	Capsulotomy, other than by laser (Assist.) (Anaes.)	$551.70
42737	Needling of posterior capsule (Assist.) (Anaes.)	$551.70
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.	$452.90
42739	Paracentesis of anterior chamber or vitreous cavity, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure, for a patient requiring anaesthetic services. (Anaes.)	$452.90
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.)	$551.70

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 (Assist.) (Anaes.)	$1,157.80
42744	Needling for drainage of encysted bleb, following trabeculectomy (Anaes.)	$516.40
42746	Glaucoma, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Assist.) (Anaes.)	$1,791.70
42749	Glaucoma, filtering operation for, where previous filtering operation has been performed (Assist.) (Anaes.)	$2,145.40
42752	Glaucoma, insertion of drainage device incorporating an extraocular reservoir for, such as a molteno device (Assist.) (Anaes.)	$2,431.50
42755	Glaucoma, removal of drainage device incorporating an extraocular reservoir for, such as a molteno device (Anaes.)	$297.80
42758	Goniotomy (Assist.) (Anaes.)	$1,266.10
42761	Division of anterior or posterior synechiae, as an independent procedure, other than by laser (Assist.) (Anaes.)	$946.50
42764	Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (Assist.) (Anaes.)	$889.20
42767	Tumour, involving ciliary body or ciliary body and iris, excision of (Assist.) (Anaes.)	$2,216.90
42770	Cyclodestructive procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Assist.) (Anaes.)	$595.00
42773	Detached retina, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Assist.) (Anaes.)	$1,654.80
42776	Detached retina, buckling or resection operation for (Assist.) (Anaes.)	$2,422.30
42779	Detached retina, revision operation for (Assist.) (Anaes.)	$2,695.60
42782	Laser trabeculoplasty, for the treatment of glaucoma. each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Assist.) (Anaes.)	$559.10
42783	Laser trabeculoplasty - each treatment to 1 eye - where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period (Assist.) (Anaes.)	$696.20
42785	Laser iridotomy - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Assist.) (Anaes.)	$551.40
42786	Laser iridotomy - each treatment episode to 1 eye - where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period (Assist.) (Anaes.)	$551.40
42788	Laser capsulotomy - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Assist.) (Anaes.)	$551.40
42789	Laser capsulotomy - each treatment episode to 1 eye - where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period (Assist.) (Anaes.)	$551.40
42791	Laser vitreolysis or corticolysis of lens material or fibrinolysis - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Assist.) (Anaes.)	$551.40
42792	Laser vitreolysis or corticolysis of lens material or fibrinolysis - each treatment to 1 eye - where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period (Assist.) (Anaes.)	$551.40
42794	Division of suture by laser following trabeculoplasty, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)	$108.10

42797	Laser coagulation of corneal or scleral blood vessels - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.)	$119.90
42801	Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Assist.) (Anaes.)	$2,012.00
42802	Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Assist.) (Anaes.)	$1,064.00
42805	Tantalum markers, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Assist.) (Anaes.)	$928.10
42806	Iris tumour, laser photocoagulation of (Assist.) (Anaes.)	$635.00
42807	Photomydriasis, laser	$523.80
42808	Photoiridosyneresis, laser	$523.80
42809	Retina, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Assist.) (Anaes.)	$759.10
42810	Phototherapeutic keratectomy, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)	$1,205.00
42811	Transpupillary thermotherapy, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.)	$776.80
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.)	$299.40
42815	Vitreous cavity, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Assist.) (Anaes.)	$1,056.50
42818	Retina, cryotherapy to, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.)	$1,074.80
42821	Ocular Transillumination, for the diagnosis and measurement of intraocular tumours (Anaes.)	$154.50
42824	Retrobulbar injection of alcohol or other drug, as an independent procedure	$117.50
42833	Squint, operation for, on 1 or both eyes, the operation involving a total of 1 or 2 muscles on a patient aged 15 years or over (Assist.) (Anaes.)	$1,325.00
42836	Squint, operation for, on 1 or both eyes, the operation involving a total of 1 or 2 muscles, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Assist.) (Anaes.)	$1,548.10
42839	Squint, operation for, on 1 or both eyes, the operation involving a total of 3 or more muscles on a patient aged 15 years or over (Assist.) (Anaes.)	$1,530.00
42842	Squint, operation for, on 1 or both eyes, the operation involving a total of 3 or more muscles, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Assist.) (Anaes.)	$1,870.00
42845	Readjustment of adjustable sutures, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)	$388.90
42848	Squint, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Assist.) (Anaes.)	$1,530.00
42851	Squint, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Assist.) (Anaes.)	$1,580.00

42854	Ruptured medial palpebral ligament or ruptured extraocular muscle, repair of (Assist.) (Anaes.)	$633.10
42857	Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (Assist.) (Anaes.)	$700.40
42860	Eyelid (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Assist.) (Anaes.)	$1,496.60
42863	Eyelid, recession of (Assist.) (Anaes.)	$1,415.00
42866	Entropion or tarsal ectropion, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Assist.) (Anaes.)	$1,360.60
42869	Eyelid closure in facial nerve paralysis, insertion of foreign implant for (Assist.) (Anaes.)	$1,026.80
42872	Eyebrow, elevation of, for paretic states (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.	$789.70
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.	$859.90
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.	$139.40

Operations for osteomyelitis

43500	Operation on phalanx (for acute osteomyelitis) (Anaes.)	$215.20
43503	Operation on sternum, clavicle, rib, ulna, radius, carpus, tibia, fibula, tarsus, skull, mandible or maxilla (other than alveolar margins) (for acute osteomyelitis) 1 bone (Anaes.)	$378.00
43506	Operation on humerus or femur (for acute osteomyelitis) 1 bone (Assist.) (Anaes.)	$648.10
43509	Operation on spine or pelvic bones (for acute osteomyelitis) 1 bone (Assist.) (Anaes.)	$617.90
43512	Operation on scapula, sternum, clavicle, rib, ulna, radius, metacarpus, carpus, phalanx, tibia, fibula, metatarsus, tarsus, mandible or maxilla (other than alveolar margins) (for chronic osteomyelitis) 1 bone or any combination of adjoining bones (Assist.) (Anaes.)	$652.50
43515	Operation on humerus or femur (for chronic osteomyelitis) 1 bone (Assist.) (Anaes.)	$652.50
43518	Operation on spine or pelvic bones (for chronic osteomyelitis) 1 bone (Assist.) (Anaes.)	$1,080.80
43521	Operation on skull (for chronic osteomyelitis) (Assist.) (Anaes.)	$767.70
43524	Operation on any combination of adjoining bones, being bones referred to in item 43515, 43518 or 43521 (for chronic osteomyelitis) (Assist.) (Anaes.)	$998.20

Paediatric

43801	Intestinal malrotation with or without volvulus, laparotomy for, not involving bowel resection (Assist.) (Anaes.)	$1,507.30
43804	Intestinal malrotation with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Assist.) (Anaes.)	$1,604.90
43807	Duodenal atresia or stenosis, duodenoduodenostomy or duodenojejunostomy for (Assist.) (Anaes.)	$1,750.80
43810	Jejunal atresia, bowel resection and anastomosis for, with or without tapering (Assist.) (Anaes.)	$2,042.70
43813	Meconium ileus, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (Assist.) (Anaes.)	$2,042.70

43816	Ileal atresia, colonic atresia or meconium ileus not being a service associated with a service to which item 43813 applies, laparotomy for (Assist.) (Anaes.)	$1,896.60
43819	Hirschsprung's disease, laparotomy for, with or without frozen section biopsies and formation of stoma (Assist.) (Anaes.)	$1,531.90
43822	Anorectal malformation, laparotomy and colostomy for (Assist.) (Anaes.)	$1,531.90
43825	Neonatal alimentary obstruction, laparotomy for, not being a service to which any other item in this Subgroup applies (Assist.) (Anaes.)	$1,750.80
43828	Acute neonatal necrotising enterocolitis, laparotomy for, with resection, including any anastomoses or stoma formation (Assist.) (Anaes.)	$1,934.50
43831	Acute neonatal necrotising enterocolitis where no definitive procedure is possible, laparotomy for (Assist.) (Anaes.)	$1,507.30
43834	Bowel resection for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Assist.) (Anaes.)	$1,750.80
43837	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Assist.) (Anaes.)	$2,188.30
43840	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Assist.) (Anaes.)	$1,896.60
43843	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Assist.) (Anaes.)	$2,918.00
43846	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Assist.) (Anaes.)	$3,136.70
43849	Oesophageal atresia, gastrostomy for (Assist.) (Anaes.)	$802.50
43852	Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Assist.) (Anaes.)	$2,553.10
43855	Oesophageal atresia, delayed primary anastomosis for (Assist.) (Anaes.)	$2,699.30
43858	Oesophageal atresia, cervical oesophagostomy for (Assist.) (Anaes.)	$948.20
43861	Congenital cystadenomatoid malformation or congenital lobar emphysema, thoracotomy and lung resection for (Assist.) (Anaes.)	$2,626.20
43864	Gastroschisis, operation for (Assist.) (Anaes.)	$1,969.60
43867	Gastroschisis, secondary operation for, with removal of silo and closure of abdominal wall (Assist.) (Anaes.)	$1,094.40
43870	Exomphalos containing small bowel only, operation for (Assist.) (Anaes.)	$1,531.90
43873	Exomphalos containing small bowel and other viscera, operation for (Assist.) (Anaes.)	$2,042.70
43876	Sacrococcygeal teratoma, excision of, by posterior approach (Assist.) (Anaes.)	$1,750.80
43879	Sacrococcygeal teratoma, excision of, by combined posterior and abdominal approach (Assist.) (Anaes.)	$2,042.70
43882	Cloacal exstrophy, operation for (Assist.) (Anaes.)	$2,626.20
43900	Tracheo-oesophageal fistula without atresia, division and repair of (Assist.) (Anaes.)	$1,750.80
43903	Oesophageal atresia or corrosive oesophageal stricture, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Assist.) (Anaes.)	$2,918.00
43906	Oesophagus, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Assist.) (Anaes.)	$2,553.10
43909	Tracheomalacia, aortopexy for (Assist.) (Anaes.)	$2,553.10

43912	Thoracotomy and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Assist.) (Anaes.)	$2,412.00
43915	Eventration, plication of diaphragm for (Assist.) (Anaes.)	$1,902.60
43930	Hypertrophic pyloric stenosis, pyloromyotomy for (Assist.) (Anaes.)	$701.30
43933	Idiopathic intussusception, laparotomy and manipulative reduction of (Assist.) (Anaes.)	$820.90
43936	Intussusception, laparotomy and resection with anastomosis (Assist.) (Anaes.)	$1,531.90
43939	Ventral hernia following neonatal closure of exomphalos or gastroschisis, repair of (Assist.) (Anaes.)	$1,167.30
43942	Abdominal wall vitello intestinal remnant, excision of (Anaes.)	$415.20
43945	Patent vitello intestinal duct, excision of (Assist.) (Anaes.)	$1,531.90
43948	Umbilical granuloma, excision of, under general anaesthesia (Anaes.)	$219.00
43951	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Assist.) (Anaes.)	$1,371.90
43954	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Assist.) (Anaes.)	$1,677.90
43957	Gastro-oesophageal reflux, laparotomy and fundoplication for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Assist.) (Anaes.)	$1,823.70
43960	Anorectal malformation, perineal anoplasty of (Assist.) (Anaes.)	$641.50
43963	Anorectal malformation, posterior sagittal anorectoplasty of (Assist.) (Anaes.)	$2,553.10
43966	Anorectal malformation, posterior sagittal anorectoplasty of, with laparotomy (Assist.) (Anaes.)	$2,918.00
43969	Persistent cloaca, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Assist.) (Anaes.)	$4,012.20
43972	Choledochal cyst, resection of, with 1 duct anastomosis (Assist.) (Anaes.)	$2,964.90
43975	Choledochal cyst, resection of, with 2 duct anastomoses (Assist.) (Anaes.)	$3,428.70
43978	Biliary atresia, portoenterostomy for (Assist.) (Anaes.)	$2,918.00
43981	Nephroblastoma, neuroblastoma or other malignant tumour, laparotomy (exploratory), including associated biopsies, where no other intra- abdominal procedure is performed (Assist.) (Anaes.)	$802.50
43984	Nephroblastoma, radical nephrectomy for (Assist.) (Anaes.)	$2,042.70
43987	Neuroblastoma, radical excision of (Assist.) (Anaes.)	$2,261.40
43990	Hirschsprung's disease, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Assist.) (Anaes.)	$2,772.20
43993	Hirschsprung's disease, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Assist.) (Anaes.)	$2,991.00
43996	Hirschsprung's disease, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolonic anastomosis (Assist.) (Anaes.)	$3,355.70
43999	Hirschsprung's disease, anal sphincterotomy as an independent procedure for (Assist.) (Anaes.)	$419.70
44102	Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Assist.) (Anaes.)	$463.20
44105	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia (Anaes.)	$71.00

44108	Inguinal hernia repair at age less than 3 months (Assist.) (Anaes.)	$773.90
44111	Obstructed or strangulated inguinal hernia, repair of, at age less than 3 months, including orchidopexy when performed (Assist.) (Anaes.)	$906.30
44114	Inguinal hernia repair at age less than 3 months when orchidopexy also required (Assist.) (Anaes.)	$906.30
44130	Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (Assist.) (Anaes.)	$761.60
44133	Torticollis, open division of sternomastoid muscle for (Assist.) (Anaes.)	$710.90
44136	Ingrown toe nail, operation for, under general anaesthesia (Anaes.)	$289.10

Amputations

44325	Hand, midcarpal or transmetacarpal, amputation of (Assist.) (Anaes.)	$530.70
44328	Hand, forearm or through arm, amputation of (Assist.) (Anaes.)	$563.90
44331	Amputation at shoulder (Assist.) (Anaes.)	$930.00
44334	Interscapulothoracic amputation (Assist.) (Anaes.)	$1,980.60
44338	1 digit of foot, amputation of (Anaes.)	$264.70
44342	2 digits of 1 foot, amputation of (Anaes.)	$484.50
44346	3 digits of 1 foot, amputation of (Assist.) (Anaes.)	$496.70
44350	4 digits of 1 foot, amputation of (Assist.) (Anaes.)	$456.10
44354	5 digits of 1 foot, amputation of (Assist.) (Anaes.)	$617.70
44358	Toe, including metatarsal or part of metatarsal each toe, amputation of (Anaes.)	$335.10
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 (Assist.) (Anaes.)	$479.90
44361	Foot at ankle (Syme, Pirogoff types), amputation of (Assist.) (Anaes.)	$563.90
44364	Foot, midtarsal or transmetatarsal, amputation of (Assist.) (Anaes.)	$507.00
44367	Amputation through thigh, at knee or below knee (Assist.) (Anaes.)	$920.20
44370	Amputation at hip (Assist.) (Anaes.)	$1,139.80
44373	Hindquarter, amputation of (Assist.) (Anaes.)	$2,339.70
44376	Amputation stump, reamputation of, to provide adequate skin and muscle cover (Assist.)	DF

Derived fee: 75% of the original amputation fee.

Plastic and reconstructive surgery

45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.)	$1,035.70
45003	Single stage local myocutaneous flap repair to 1 defect, simple and small (Anaes.)	$1,108.20
45006	Single stage large myocutaneous flap repair to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Assist.) (Anaes.)	$2,004.70
45009	Single stage local muscle flap repair to 1 defect, simple and small (Assist.) (Anaes.)	$749.30
45012	Single stage large muscle flap repair to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Assist.) (Anaes.)	$1,153.90
45015	Muscle or myocutaneous flap, delay of (Anaes.)	$735.00

45018	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) (Assist.) (Anaes.)	$1,168.00
45019	Full face chemical peel for severely sun-damaged skin, where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - 1 session only in a 12 month period (Anaes.)	$796.80
45020	Full face chemical peel for severe chloasma or melasma refractory to all other treatments, where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - 1 session only in a 12 month period (Anaes.)	$940.00
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.)	$218.50
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.)	$214.80
45033	Angioma (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.)	$438.90
45035	Angioma (haemangioma or lymphangioma or both) large and deep, involving muscles or nerves, excision of (Assist.) (Anaes.)	$1,276.00
45036	Angioma (haemangioma or lymphangioma or both) of neck, deep, excision of (Assist.) (Anaes.)	$2,060.90
45039	Arteriovenous malformation (3 cms or less) of superficial tissue, excision of (Anaes.)	$437.10
45042	Arteriovenous malformation, (greater than 3 cms), excision of (Assist.) (Anaes.)	$560.10
45045	Arteriovenous malformation on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)	$570.00
45048	Lymphoedematous tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Assist.) (Anaes.)	$1,722.10
45051	Contour reconstruction for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Assist.) (Anaes.)	$1,125.00
45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Assist.) (Anaes.)	$388.10
45200	Single stage local flap, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness and excluding h-flap or double advancement flap (Anaes.)	$507.00

45203	Single stage local flap, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness and excluding h-flap or double advancement flap (Assist.) (Anaes.)	$744.00
45206	Single stage local flap where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, and excluding h-flap or double advancement flap (Anaes.)	$698.60
45207	H-flap or double advancement flap where indicated to repair 1 defect, on eyelid, eyebrow or forehead (Anaes.)	$636.20
45209	Direct flap repair (cross arm, abdominal or similar), first stage (Assist.) (Anaes.)	$891.30
45212	Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.)	$442.30
45215	Direct flap repair, cross leg, first stage (Assist.) (Anaes.)	$1,934.10
45218	Direct flap repair, cross leg, second stage (Assist.) (Anaes.)	$870.00
45221	Direct flap repair, small (cross finger or similar), first stage (Anaes.)	$536.60
45224	Direct flap repair, small (cross finger or similar), second stage (Anaes.)	$231.60
45227	Indirect flap or tubed pedicle, formation of (Assist.) (Anaes.)	$850.00
45230	Direct or indirect flap or tubed pedicle, delay of (Anaes.)	$470.20
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (Assist.) (Anaes.)	$964.80
45236	Indirect flap or tubed pedicle, spreading of pedicle, as a separate procedure (Anaes.)	$767.40
45239	Direct, indirect or local flap, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.)	$469.70
45240	Direct, indirect or local flap, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)	$463.80
45400	Free grafting (split skin) of a granulating area, small (Anaes.)	$370.90
45403	Free grafting (split skin) of a granulating area, extensive (Assist.) (Anaes.)	$739.20
45406	Free grafting (split skin) to burns, including excision of burnt tissue - involving not more than 3% of total body surface (Assist.) (Anaes.)	$917.10
45409	Free grafting (split skin) to burns, including excision of burnt tissue - involving 3% or more but less than 6% of total body surface (Assist.) (Anaes.)	$1,099.00
45412	Free grafting (split skin) to burns, including excision of burnt tissue - involving 6% or more but less than 9% of total body surface (Assist.) (Anaes.)	$1,706.90
45415	Free grafting (split skin) to burns, including excision of burnt tissue - involving 9% or more but less than 12% of total body surface (Assist.) (Anaes.)	$1,645.10
45418	Free grafting (split skin) to burns, including excision of burnt tissue - involving 12% or more but less than 15 per cent of total body surface (Assist.) (Anaes.)	$1,546.90
45439	Free grafting (split skin) to 1 defect, including elective dissection, small (Anaes.)	$516.10
45442	Free grafting (split skin) to 1 defect, including elective dissection, extensive (Assist.) (Anaes.)	$1,076.10
45445	Free grafting (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould) (Assist.) (Anaes.)	$1,026.20
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.)	$684.70
45451	Free grafting (full thickness) to 1 defect, excluding grafts for male pattern baldness (Assist.) (Anaes.)	$849.20

45460	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - one surgeon (Assist.) (Anaes.)	$1,983.50
45461	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$2,261.20
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.)	$1,066.70
45464	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - one surgeon (Assist.) (Anaes.)	$5,130.00
45465	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$2,156.90
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.)	$1,626.80
45468	Free grafting (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$2,900.20
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.)	$2,538.80
45471	Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$3,645.60
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.)	$2,749.80
45474	Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$4,388.80
45475	Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$3,311.30
45477	Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$5,132.20
45478	Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$3,871.00
45480	Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$5,875.30
45481	Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	$4,432.90
45483	Free grafting (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.)	$6,694.00
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.)	$5,050.70

45485	Free grafting (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Assist.) (Anaes.)	$1,571.40
45486	Free grafting (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Assist.) (Anaes.)	$1,031.40
45487	Free grafting (split skin) to burns, including excision of burnt tissue - whole of toe (Assist.) (Anaes.)	$642.60
45488	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Assist.) (Anaes.)	$714.00
45489	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Assist.) (Anaes.)	$1,071.10
45490	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Assist.) (Anaes.)	$1,852.50
45491	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Assist.) (Anaes.)	$1,785.10
45492	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Assist.) (Anaes.)	$3,082.80
45493	Free grafting (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Assist.) (Anaes.)	$965.00
45494	Free grafting (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Assist.) (Anaes.)	$2,945.00
45496	Flap, free tissue transfer using microvascular techniques - revision of, by open operation (Anaes.)	$810.30
45497	Flap, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - complete revision of, by liposuction (Anaes.)	$633.60
45498	Flap, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - staged revision of, by liposuction - first stage (Anaes.)	$510.90
45499	Flap, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - staged revision of, by liposuction - second stage (Anaes.)	$379.90
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Assist.) (Anaes.)	$2,001.50
45501	Microvascular anastomosis of artery using microsurgical techniques, for re- implantation of limb or digit (Assist.) (Anaes.)	$3,220.60
45502	Microvascular anastomosis of vein using microsurgical techniques, for re- implantation of limb or digit (Assist.) (Anaes.)	$4,005.00
45503	Micro-arterial or micro-venous graft using microsurgical techniques (Assist.) (Anaes.)	$3,499.60
45504	Microvascular anastomosis of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Assist.) (Anaes.)	$3,291.50
45505	Microvascular anastomosis of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Assist.) (Anaes.)	$3,253.30
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.)	$413.80
45512	Scar, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)	$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.)	$335.00
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 (Assist.) (Anaes.)	$1,050.00
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple (Assist.) (Anaes.)	$2,200.00
45522	Reduction mammaplasty (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (Assist.) (Anaes.)	$1,545.00
45524	Mammaplasty, augmentation, for significant breast asymmetry where the augmentation is limited to 1 breast (Assist.) (Anaes.)	$1,605.00
45527	Mammaplasty, augmentation, (unilateral), following mastectomy (Assist.) (Anaes.)	$1,610.00
45528	Mammaplasty, augmentation, bilateral, not being a service to which Item 45527 applies, where it can be demonstrated that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery) (Assist.) (Anaes.)	$2,415.00
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, not being a service associated with a service to which items 30165, 30168, 30171, 30174 or 30177 applies (Assist.) (Anaes.)	$2,375.00
45533	Breast reconstruction using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Assist.) (Anaes.)	$2,690.00
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 (Assist.) (Anaes.)	$841.90
45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Assist.) (Anaes.)	$2,300.20
45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Assist.) (Anaes.)	$1,320.00
45545	Nipple or areola or both, reconstruction of, by any surgical technique (Assist.) (Anaes.)	$1,220.60
45546	Nipple or areola or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	$315.90
45548	Breast prosthesis, removal of, as an independent procedure (Anaes.)	$680.00
45551	Breast prosthesis, removal of, with excision of fibrous capsule (Assist.) (Anaes.)	$1,085.00
45552	Breast prosthesis, removal of, with excision of fibrous capsule and replacement of prosthesis (Assist.) (Anaes.)	$1,440.00
45553	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation). (Assist.) (Anaes.)	$1,440.00
45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Assist.) (Anaes.)	$1,715.00
45555	Silicone breast prosthesis, removal of and replacement with prosthesis other than silicone gel prosthesis (Assist.) (Anaes.)	$1,440.00

45556	Breast ptosis, correction of (unilateral), to match the position of the contralateral breast (Assist.) (Anaes.)	$1,870.00
45557	Breast ptosis, correction of by mastopexy by any means (unilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra- mammary groove, not being a service associated with a service to which item 45522 applies (Assist.) (Anaes.)	$1,870.00
45558	Breast ptosis, correction of by mastopexy by any means (bilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra- mammary groove, not being a service associated with a service to which item 45522 applies (Assist.) (Anaes.)	$2,805.00
45559	Tuberous, tubular or constricted breast, where it can be demonstrated, correction of by simultaneous mastopexy and augmentation of (unilateral) (Assist.) (Anaes.)	$2,770.00
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.)	$1,110.00
45561	Microvascular anastomosis of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Assist.) (Anaes.)	$3,487.50
45562	Free transfer of tissue involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Assist.) (Anaes.)	$2,007.10
45563	Neurovascular island flap, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Assist.) (Anaes.)	$2,014.90
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 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Assist.) (Anaes.)	$5,017.20
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 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.)	$3,508.40
45566	Tissue expansion not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Assist.) (Anaes.)	$2,096.40
45568	Tissue expander, removal of, with complete excision of fibrous capsule (Assist.) (Anaes.)	$733.40
45569	Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Assist.) (Anaes.)	$1,430.00
45570	Closure of abdomen, repair of musculoaponeurotic layer, being a service associated with item 45569 (Assist.) (Anaes.)	$1,895.00
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.)	$556.80

45575	Facial nerve paralysis, free fascia graft for (Assist.) (Anaes.)	$1,440.40
45578	Facial nerve paralysis, muscle transfer for (Assist.) (Anaes.)	$1,604.90
45581	Facial nerve palsy, excision of tissue for (Anaes.)	$680.00
45584	Liposuction (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.)	$1,550.00
45585	Liposuction (suction assisted lipolysis) to 1 regional area, not being a service associated with a service to which item 31521 or 31527 applies, where it can be demonstrated that the treatment is for barraquer- simon's syndrome (pathological lipodystrophy of hips, buttocks, thighs, knees or lower legs), lymphoedema or macrodystrophia lipomatosa (Anaes.)	$1,550.00
45586	Liposuction (suction assisted lipolysis) for reduction of a buffalo hump, where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition (Anaes.)	$1,550.00
45587	Meloplasty for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Assist.) (Anaes.)	$1,865.00
45588	Meloplasty, (excluding browlifts and chinlift platysmaplasties), bilateral where it can be demonstrated that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (Assist.) (Anaes.)	$2,790.00
45590	Orbital cavity, reconstruction of a wall or floor, with or without foreign implant (Assist.) (Anaes.)	$1,015.00
45593	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Assist.) (Anaes.)	$1,190.00
45596	Maxilla, total resection of (Assist.) (Anaes.)	$1,960.00
45597	Maxilla, total resection of both maxillae (Assist.) (Anaes.)	$1,907.50
45599	Mandible, total resection of both sides, including condylectomies where performed (Assist.) (Anaes.)	$1,177.40
45602	Mandible, including lower border, or maxilla, sub-total resection of (Assist.) (Anaes.)	$1,331.80
45605	Mandible or maxilla, segmental resection of, for tumours or cysts (Assist.) (Anaes.)	$1,076.80
45608	Mandible, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Assist.) (Anaes.)	$1,686.50
45611	Mandible, condylectomy (Assist.) (Anaes.)	$1,265.00
45614	Eyelid, whole thickness reconstruction of, other than by direct suture only (Assist.) (Anaes.)	$1,074.90
45617	Upper eyelid, reduction of, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.)	$495.00
45620	Lower eyelid, reduction of, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.)	$685.00
45623	Ptosis of eyelid (unilateral), correction of (Assist.) (Anaes.)	$1,419.20
45624	Ptosis of eyelid, correction of, where previous ptosis surgery has been performed on that side (Assist.) (Anaes.)	$1,605.20
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.)	$327.70
45626	Ectropion or entropion, correction of (unilateral) (Anaes.)	$655.00

45629	Symblepharon, grafting for (Assist.) (Anaes.)	$1,110.00
45632	Rhinoplasty, correction of lateral or alar cartilages (Anaes.)	$1,215.00
45635	Rhinoplasty, correction of bony vault only (Anaes.)	$1,440.00
45638	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity (but not as a result of previous elective cosmetic surgery), or both (Anaes.)	$2,490.00
45639	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, where it can be demonstrated that there is a need for correction of significant developmental deformity (Anaes.)	$2,485.00
45641	Rhinoplasty involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.)	$2,550.00
45644	Rhinoplasty involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Assist.) (Anaes.)	$2,985.00
45645	Choanal atresia, repair of by puncture and dilatation (Anaes.)	$354.00
45646	Choanal atresia, correction by open operation with bone removal (Assist.) (Anaes.)	$1,952.30
45647	Face, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Assist.) (Anaes.)	$2,955.90
45650	Rhinoplasty, secondary revision of (Anaes.)	$330.00
45652	Rhinophyma, carbon dioxide laser or erbium laser excision-ablation of (Anaes.)	$745.00
45653	Rhinophyma, shaving of (Anaes.)	$704.20
45656	Composite graft (chondrocutaneous or chondromucosal) to nose, ear or eyelid (Assist.) (Anaes.)	$1,132.90
45659	Lop ear, bat ear or similar deformity, correction of (Anaes.)	$1,145.00
45660	External ear, complex total reconstruction of, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Assist.) (Anaes.)	$5,157.40
45661	External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Assist.) (Anaes.)	$2,357.80
45662	Congenital atresia, reconstruction of external auditory canal (Assist.) (Anaes.)	$1,143.00
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures (Anaes.)	$595.80
45668	Vermilionectomy, by surgical excision (Anaes.)	$616.10
45669	Vermilionectomy, using carbon dioxide laser or erbium laser excision- ablation (Anaes.)	$646.40
45671	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), first stage (Assist.) (Anaes.)	$1,610.00
45674	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$483.40
45675	Macrocheilia or macroglossia, operation for (Assist.) (Anaes.)	$884.40
45676	Macrostomia, operation for (Assist.) (Anaes.)	$1,049.00
45677	Cleft lip, unilateral primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.)	$979.90
45680	Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.)	$1,071.10
45683	Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.)	$1,190.00

45686	Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.)	$1,549.60
45689	Cleft lip, lip adhesion procedure, unilateral or bilateral (Assist.) (Anaes.)	$600.00
45692	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$565.00
45695	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Assist.) (Anaes.)	$1,075.00
45698	Cleft lip, primary columella lengthening procedure, bilateral (Anaes.)	$725.90
45701	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Assist.) (Anaes.)	$2,320.80
45704	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$526.80
45707	Cleft palate, primary repair (Assist.) (Anaes.)	$1,258.80
45710	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.)	$841.90
45713	Cleft palate, secondary repair, lengthening procedure (Assist.) (Anaes.)	$997.10
45714	Oro-nasal fistula, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Assist.) (Anaes.)	$1,357.80
45716	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.)	$1,768.80
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 (Assist.) (Anaes.)	$1,769.00
45723	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,495.00
45726	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,243.40
45729	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$3,170.00
45731	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,550.60
45732	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$3,615.00
45735	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,951.80
45738	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$3,815.60
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	$2,804.80

	from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	
45744	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$4,565.00
45747	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$3,059.80
45752	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$4,353.90
45753	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$3,447.70
45754	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar- Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$4,766.10
45755	Temporomandibular partial or total meniscectomy (Assist.) (Anaes.)	$581.90
45758	Temporo-mandibular joint, arthroplasty (Assist.) (Anaes.)	$1,208.00
45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$1,580.00
45767	Hypertelorism, correction of, intracranial (Assist.) (Anaes.)	$3,974.70
45770	Hypertelorism, correction of, subcranial (Assist.) (Anaes.)	$3,044.70
45773	Treacher Collins Syndrome, periorbital correction of, with rib and iliac bone grafts (Assist.) (Anaes.)	$2,774.90
45776	Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, intracranial (Assist.) (Anaes.)	$2,837.30
45779	Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, extracranial (Assist.) (Anaes.)	$2,040.20
45782	Frontoorbital advancement, unilateral (Assist.) (Anaes.)	$1,804.00
45785	Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral fronto-orbital advancement) (Assist.) (Anaes.)	$2,639.70
45788	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of, (Obwegeser technique) (Assist.) (Anaes.)	$2,666.90
45791	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Assist.) (Anaes.)	$1,409.80
45794	Osseo-integration procedure - extra- oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)	$1,235.00
45797	Osseo-integration procedure, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)	$371.60

45799	Aspiration biopsy of 1 or more jaw cysts as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.)	$72.00
45801	Tumour, cyst, ulcer or scar, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.)	$264.80
45803	Tumours, cysts, ulcers or scars, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Assist.) (Anaes.)	$597.80
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.)	$416.00
45809	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this subgroup applies (Assist.) (Anaes.)	$681.90
45811	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Assist.) (Anaes.)	$916.90
45813	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Assist.) (Anaes.)	$1,110.10
45815	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Assist.) (Anaes.)	$642.00
45817	Operation on skull for osteomyelitis (Assist.) (Anaes.)	$735.10
45819	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 45817 (Assist.) (Anaes.)	$1,964.90
45821	Bone growth stimulator in the oral and maxillofacial region, insertion of (Assist.) (Anaes.)	$642.80
45823	Arch bars, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.)	$265.00
45825	Mandibular or palatal exostosis, excision of (Assist.) (Anaes.)	$595.60
45827	Mylohyoid ridge, reduction of (Assist.) (Anaes.)	$545.80
45829	Maxillary tuberosity, reduction of (Anaes.)	$416.50
45831	Papillary hyperplasia of the palate, removal of - less than 5 lesions (Assist.) (Anaes.)	$545.80
45833	Papillary hyperplasia of the palate, removal of - 5 to 20 lesions (Assist.) (Anaes.)	$642.60
45835	Papillary hyperplasia of the palate, removal of - more than 20 lesions (Assist.) (Anaes.)	$797.30

45837	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Assist.) (Anaes.)	$989.80
45839	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Assist.) (Anaes.)	$989.80
45841	Alveolar ridge augmentation with bone or alloplast or both - unilateral (Assist.) (Anaes.)	$832.80
45843	Alveolar ridge augmentation - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Assist.) (Anaes.)	$705.00
45845	Osseo-integration procedure - intra- oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$898.30
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.)	$314.90
45849	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Assist.) (Anaes.)	$1,124.10
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.)	$241.20
45853	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Assist.) (Anaes.)	$1,409.80
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Assist.) (Anaes.)	$646.80
45857	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Assist.) (Anaes.)	$1,034.70
45859	Temporomandibular joint, arthrotomy of, not being a service to which another item in this subgroup applies (Assist.) (Anaes.)	$521.50
45861	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Assist.) (Anaes.)	$1,582.50
45863	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Assist.) (Anaes.)	$2,249.10
45865	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Assist.) (Anaes.)	$523.80
45867	Temporomandibular joint, synovectomy of, not being a service to which another item in this subgroup applies (Assist.) (Anaes.)	$494.40
45869	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Assist.) (Anaes.)	$1,880.40
45871	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Assist.) (Anaes.)	$3,260.00
45873	Temporomandibular joint, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Assist.) (Anaes.)	$2,754.30
45875	Temporomandibular joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Assist.) (Anaes.)	$1,075.90

45877	Temporomandibular joint, arthrodesis of, with synovectomy if performed, not being a service to which another item in this subgroup applies (Assist.) (Anaes.)	$744.80
45879	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Assist.) (Anaes.)	$780.00
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser.	$68.00
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Assist.) (Anaes.)	$723.10
45888	Foreign body, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Assist.) (Anaes.)	$649.60
45891	Single-stage local flap where indicated, repair to 1 defect, using temporalis muscle (Assist.) (Anaes.)	$981.90
45894	Free grafting, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.)	$446.90
45897	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro- nasal fistulae and ridge augmentation (Assist.) (Anaes.)	$1,683.30
45900	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	$440.90
45939	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Assist.) (Anaes.)	$835.00
45945	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	$187.90
45975	Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting	$204.50
45978	Mandible, treatment of fracture of, not requiring splinting	$249.70
45981	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	$156.70
45984	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Assist.) (Anaes.)	$975.90
45987	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Assist.) (Anaes.)	$1,230.90
45990	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Assist.) (Anaes.)	$1,428.90
45993	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Assist.) (Anaes.)	$1,800.50
45996	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	$378.00

Hand surgery

46300	Inter-phalangeal joint or metacarpophalangeal joint, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$701.70
46303	Carpometacarpal joint, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$738.20
46306	Inter-phalangeal joint or metacarpophalangeal joint - interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Assist.) (Anaes.)	$1,118.50
46307	Interphalangeal joint or metacarpophalangeal joint - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Assist.) (Anaes.)	$1,000.10
46309	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Assist.) (Anaes.)	$1,027.20
46312	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2	$1,299.00

	joints (Assist.) (Anaes.)	
46315	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Assist.) (Anaes.)	$1,745.10
46318	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Assist.) (Anaes.)	$2,354.00
46321	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Assist.) (Anaes.)	$2,603.40
46324	Carpal bone replacement arthroplasty including associated tendon transfer or realignment when performed (Assist.) (Anaes.)	$1,694.10
46325	Carpal bone replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Assist.) (Anaes.)	$1,700.40
46327	Inter-phalangeal joint or metacarpophalangeal joint, arthrotomy of (Anaes.)	$443.30
46330	Inter-phalangeal joint or metacarpophalangeal joint, ligamentous or capsular repair with or without arthrotomy (Assist.) (Anaes.)	$766.40
46333	Inter-phalangeal joint or metacarpophalangeal joint, ligamentous repair of, using free tissue graft or implant (Assist.) (Anaes.)	$1,126.70
46336	Inter-phalangeal joint or metacarpophalangeal joint, synovectomy, capsulectomy or debridement of, not being a service associated with any other procedure related to that joint (Assist.) (Anaes.)	$669.40
46339	Extensor tendons or flexor tendons of hand or wrist, synovectomy of (Assist.) (Anaes.)	$919.30
46342	Distal radioulnar joint or carpometacarpal joint or joints, synovectomy of (Assist.) (Anaes.)	$919.30
46345	Distal radioulnar joint, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Assist.) (Anaes.)	$1,126.40
46348	Digit, synovectomy of flexor tendon or tendons - 1 digit (Anaes.)	$485.00
46351	Digit, synovectomy of flexor tendon or tendons - 2 digits (Assist.) (Anaes.)	$753.20
46354	Digit, synovectomy of flexor tendon or tendons - 3 digits (Assist.) (Anaes.)	$1,001.60
46357	Digit, synovectomy of flexor tendon or tendons - 4 digits (Assist.) (Anaes.)	$1,250.00
46360	Digit, synovectomy of flexor tendon or tendons - 5 digits (Assist.) (Anaes.)	$1,498.40
46363	Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis (Anaes.)	$461.40
46366	Dupuytren's contracture, subcutaneous fasciotomy for - each hand (Anaes.)	$329.10
46369	Dupuytren's contracture, palmar fasciectomy for - 1 hand (Anaes.)	$464.40
46372	Dupuytren's contracture, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Assist.) (Anaes.)	$850.00
46375	Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Assist.) (Anaes.)	$1,008.20
46378	Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Assist.) (Anaes.)	$1,340.20
46381	Inter-phalangeal joint, joint capsule release when performed in conjunction with operation for Dupuytren's contracture - each procedure (Assist.) (Anaes.)	$593.80
46384	Z plasty (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's contracture - 1 such procedure (Assist.) (Anaes.)	$593.80

46387	Dupuytren's contracture, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Assist.) (Anaes.)	$1,221.90
46390	Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Assist.) (Anaes.)	$1,644.40
46393	Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Assist.) (Anaes.)	$1,899.40
46396	Phalanx or metacarpal of the hand, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$677.50
46399	Phalanx or metacarpal of the hand, osteotomy of, with internal fixation (Assist.) (Anaes.)	$946.50
46402	Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Assist.) (Anaes.)	$1,046.40
46405	Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Assist.) (Anaes.)	$1,141.40
46408	Tendon, reconstruction of, by tendon graft (Assist.) (Anaes.)	$1,270.10
46411	Flexor tendon pulley, reconstruction of, by graft (Assist.) (Anaes.)	$835.60
46414	Artificial tendon prosthesis, insertion of in preparation for tendon grafting (Assist.) (Anaes.)	$969.20
46417	Tendon transfer for restoration of hand function, each transfer (Assist.) (Anaes.)	$1,001.60
46420	Extensor tendon of hand or wrist, primary repair of, each tendon (Anaes.)	$414.50
46423	Extensor tendon of hand or wrist, secondary repair of, each tendon (Assist.) (Anaes.)	$669.40
46426	Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon (Assist.) (Anaes.)	$681.20
46429	Flexor tendon of hand or wrist, secondary repair of, proximal to A1 pulley, each tendon (Assist.) (Anaes.)	$835.60
46432	Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon (Assist.) (Anaes.)	$912.90
46435	Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon (Assist.) (Anaes.)	$1,026.70
46438	Mallet finger, closed pin fixation of (Anaes.)	$350.00
46441	Mallet finger, open repair of, including pin fixation when performed (Assist.) (Anaes.)	$680.80
46442	Mallet finger with intra-articular fracture involving more than one-third of base of terminal phalanx - open reduction (Assist.) (Anaes.)	$581.50
46444	Boutonniere deformity without joint contracture, reconstruction of (Assist.) (Anaes.)	$994.40
46447	Boutonniere deformity with joint contracture, reconstruction of (Assist.) (Anaes.)	$1,208.70
46450	Extensor tendon, tenolysis of, following tendon injury, repair or graft (Anaes.)	$468.90
46453	Flexor tendon, tenolysis of, following tendon injury, repair or graft (Assist.) (Anaes.)	$758.90
46456	Finger, percutaneous tenotomy of (Anaes.)	$178.50
46459	Operation for osteomyelitis on distal phalanx (Anaes.)	$485.00
46462	Operation for osteomyelitis on middle or proximal phalanx, metacarpal or carpus (Assist.) (Anaes.)	$604.70
46464	Amputation of a supernumerary complete digit (Anaes.)	$427.80
46465	Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)	$472.60

46468	Amputation of 2 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.)	$1,010.00
46471	Amputation of 3 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.)	$1,126.40
46474	Amputation of 4 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.)	$1,160.50
46477	Amputation of 5 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.)	$1,428.30
46480	Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Assist.) (Anaes.)	$746.50
46483	Revision of amputation stump to provide adequate soft tissue cover (Assist.) (Anaes.)	$593.80
46486	Nail bed, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.)	$476.70
46489	Nail bed, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Assist.) (Anaes.)	$544.60
46492	Contracture of digits of hand, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Assist.) (Anaes.)	$689.50
46494	Ganglion of hand, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$405.70
46495	Ganglion or mucous cyst of distal digit, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)	$401.10
46498	Ganglion of flexor tendon sheath, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)	$451.60
46500	Ganglion of dorsal wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Assist.) (Anaes.)	$538.10
46501	Ganglion of volar wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Assist.) (Anaes.)	$658.60
46502	Recurrent ganglion of dorsal wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Assist.) (Anaes.)	$576.40
46503	Recurrent ganglion of volar wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Assist.) (Anaes.)	$717.30
46504	Neurovascular island flap, for pulp innervation (Assist.) (Anaes.)	$2,182.40
46507	Digit or ray, transposition or transfer of, on vascular pedicle, complete procedure (Assist.) (Anaes.)	$2,353.10
46510	Macrodactyly, surgical reduction of enlarged elements - each digit (Assist.) (Anaes.)	$902.90
46513	Digital nail of finger or thumb, removal of, not being a service to which item 46516 applies (Anaes.)	$89.40
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.)	$269.60
46522	Flexor tendon sheath of finger or thumb - open operation and drainage for infection (Assist.) (Anaes.)	$848.60
46525	Pulp space infection, paronychia of hand, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after- care) (Anaes.)	$90.50

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.)	$268.20
46531	Ingrowing nail of finger or thumb, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)	$134.80
46534	Nail plate injury or deformity, radical excision of nail germinal matrix (Anaes.)	$448.90

Orthopaedic

47000	Mandible, treatment of dislocation of, by closed reduction (Anaes.)	$94.40
47003	Clavicle, treatment of dislocation of, by closed reduction (Anaes.)	$107.40
47006	Clavicle, treatment of dislocation of, by open reduction (Anaes.)	$296.70
47009	Shoulder, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.)	$259.10
47012	Shoulder, treatment of dislocation of, requiring general anaesthesia, open reduction (Assist.) (Anaes.)	$593.30
47015	Shoulder, treatment of dislocation of, not requiring general anaesthesia	$107.40
47018	Elbow, treatment of dislocation of, by closed reduction (Anaes.)	$267.70
47021	Elbow, treatment of dislocation of, by open reduction (Assist.) (Anaes.)	$465.00
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.)	$330.20
47027	Radioulnar joint, distal or proximal, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Assist.) (Anaes.)	$447.60
47030	Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by closed reduction (Anaes.)	$321.30
47033	Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by open reduction (Assist.) (Anaes.)	$465.00
47036	Interphalangeal joint, treatment of dislocation of, by closed reduction (Anaes.)	$107.40
47039	Interphalangeal joint, treatment of dislocation of, by open reduction (Anaes.)	$198.50
47042	Metacarpophalangeal joint, treatment of dislocation of, by closed reduction (Anaes.)	$144.70
47045	Metacarpophalangeal joint, treatment of dislocation of, by open reduction (Anaes.)	$261.10
47048	Hip, treatment of dislocation of, by closed reduction (Anaes.)	$507.60
47051	Hip, treatment of dislocation of, by open reduction (Assist.) (Anaes.)	$739.00
47054	Knee, treatment of dislocation of, by closed reduction (Assist.) (Anaes.)	$478.50
47057	Patella, treatment of dislocation of, by closed reduction (Anaes.)	$160.30
47060	Patella, treatment of dislocation of, by open reduction (Anaes.)	$214.80
47063	Ankle or tarsus, treatment of dislocation of, by closed reduction (Anaes.)	$320.90
47066	Ankle or tarsus, treatment of dislocation of, by open reduction (Assist.) (Anaes.)	$593.30
47069	Toe, treatment of dislocation of, by closed reduction (Anaes.)	$89.50
47072	Toe, treatment of dislocation of, by open reduction (Anaes.)	$165.70
47300	Distal phalanx of finger or thumb, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.)	$134.10
47303	Distal phalanx of finger or thumb, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$156.40
47306	Distal phalanx of finger or thumb, treatment of fracture of, by open reduction (Anaes.)	$244.40

47309	Distal phalanx of finger or thumb, treatment of intra-articular fracture of, by open reduction (Anaes.)	$296.20
47312	Middle phalanx of finger, treatment of fracture of, by closed reduction (Anaes.)	$201.10
47315	Middle phalanx of finger, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$262.30
47318	Middle phalanx of finger, treatment of fracture of, by open reduction (Anaes.)	$340.50
47321	Middle phalanx of finger, treatment of intra-articular fracture of, by open reduction (Anaes.)	$480.40
47324	Proximal phalanx of finger or thumb, treatment of fracture of, by closed reduction (Anaes.)	$282.30
47327	Proximal phalanx of finger or thumb, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$360.00
47330	Proximal phalanx of finger or thumb, treatment of fracture of, by open reduction (Anaes.)	$516.70
47333	Proximal phalanx of finger or thumb, treatment of intra-articular fracture of, by open reduction (Assist.) (Anaes.)	$592.70
47336	Metacarpal, treatment of fracture of, by closed reduction (Anaes.)	$268.20
47339	Metacarpal, treatment of intra- articular fracture of, by closed reduction (Anaes.)	$360.00
47342	Metacarpal, treatment of fracture of, by open reduction (Anaes.)	$521.60
47345	Metacarpal, treatment of intra- articular fracture of, by open reduction (Assist.) (Anaes.)	$594.00
47348	Carpus (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.)	$148.80
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.)	$268.20
47357	Carpal scaphoid, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$847.50
47360	Radius or ulna, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes.)	$208.50
47363	Radius or ulna, distal end of, treatment of fracture of, by closed reduction (Anaes.)	$335.50
47366	Radius or ulna, distal end of, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$513.60
47369	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes.)	$268.20
47372	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)	$508.10
47375	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture, by open reduction (Assist.) (Anaes.)	$760.00
47378	Radius or ulna, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.)	$268.20
47381	Radius or ulna, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)	$466.00
47384	Radius or ulna, shaft of, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$625.30
47385	Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Assist.) (Anaes.)	$539.00
47386	Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Assist.) (Anaes.)	$921.00

47387	Radius and ulna, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Assist.) (Anaes.)	$431.90
47390	Radius and ulna, shafts of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	$757.40
47393	Radius and ulna, shafts of, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$1,033.90
47396	Olecranon, treatment of fracture of, not being a service to which item 47399 applies (Anaes.)	$297.80
47399	Olecranon, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$762.00
47402	Olecranon, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Assist.) (Anaes.)	$705.00
47405	Radius, treatment of fracture of head or neck of, closed reduction of (Anaes.)	$297.80
47408	Radius, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Assist.) (Anaes.)	$797.30
47411	Humerus, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.)	$178.60
47414	Humerus, treatment of fracture of tuberosity of, by open reduction (Anaes.)	$530.80
47417	Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Assist.) (Anaes.)	$481.00
47420	Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Assist.) (Anaes.)	$1,288.40
47423	Humerus, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.)	$370.60
47426	Humerus, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	$820.00
47429	Humerus, proximal, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$856.30
47432	Humerus, proximal, treatment of intra- articular fracture of, by open reduction (Assist.) (Anaes.)	$1,041.10
47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Assist.) (Anaes.)	$748.80
47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Assist.) (Anaes.)	$1,226.50
47441	Humerus, proximal, treatment of intra- articular fracture of, and associated dislocation of shoulder, by open reduction (Assist.) (Anaes.)	$1,642.90
47444	Humerus, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.)	$373.20
47447	Humerus, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	$645.30
47450	Humerus, shaft of, treatment of fracture of, by internal or external (Assist.) (Anaes.)	$968.70
47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (Assist.) (Anaes.)	$1,159.90
47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Assist.) (Anaes.)	$417.20
47456	Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	$713.30
47459	Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Assist.) (Anaes.)	$978.80

47462	Clavicle, treatment of fracture of, not being a service to which item 47465 applies (Anaes.)	$178.60
47465	Clavicle, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$565.00
47466	Sternum, treatment of fracture of, not being a service to which item 47467 applies (Anaes.)	$178.60
47467	Sternum, treatment of fracture of, by open reduction (Anaes.)	$420.90
47468	Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$918.40
47471	Ribs (1 or more), treatment of fracture of - each attendance	$68.00
47474	Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum	$339.70
47477	Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum	$424.70
47480	Pelvic ring, treatment of fracture of, requiring traction (Assist.) (Anaes.)	$1,094.10
47483	Pelvic ring, treatment of fracture of, requiring control by external fixation (Assist.) (Anaes.)	$1,024.60
47486	Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Assist.) (Anaes.)	$1,726.60
47489	Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Assist.) (Anaes.)	$2,557.40
47492	Acetabulum, treatment of fracture of, and associated dislocation of hip (Anaes.)	$372.80
47495	Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring traction (Assist.) (Anaes.)	$854.80
47498	Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Assist.) (Anaes.)	$1,278.80
47501	Acetabulum, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$1,919.90
47504	Acetabulum, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,557.40
47507	Acetabulum, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,934.00
47510	Acetabulum, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.)	$2,557.40
47513	Sacro-iliac joint disruption, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Assist.) (Anaes.)	$595.90
47516	Femur, treatment of fracture of, by closed reduction or traction (Assist.) (Anaes.)	$751.90
47519	Femur, treatment of trochanteric or subcapital fracture of, by internal fixation (Assist.) (Anaes.)	$1,598.50
47522	Femur, treatment of subcapital fracture of, by hemi-arthroplasty (Assist.) (Anaes.)	$1,370.70
47525	Femur, treatment of fracture of, for slipped capital femoral epiphysis (Assist.) (Anaes.)	$1,599.80
47528	Femur, treatment of fracture of, by internal fixation or external fixation (Assist.) (Anaes.)	$1,364.20
47531	Femur, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Assist.) (Anaes.)	$1,736.30

47534	Femur, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Assist.) (Anaes.)	$2,125.50
47537	Femur, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Assist.) (Anaes.)	$819.30
47540	Hip spica or shoulder spica, application of, as an independent procedure (Anaes.)	$395.50
47543	Tibia, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.)	$357.70
47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)	$614.20
47549	Tibia, plateau of, treatment of medial or lateral fracture of, by open reduction (Assist.) (Anaes.)	$884.70
47552	Tibia, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Assist.) (Anaes.)	$636.50
47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)	$1,024.60
47558	Tibia, plateau of, treatment of both medial and lateral fractures of, by open reduction (Assist.) (Anaes.)	$1,498.60
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.)	$431.90
47564	Tibia, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.)	$757.40
47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (Assist.) (Anaes.)	$1,326.00
47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Assist.) (Anaes.)	$1,749.20
47567	Tibia, shaft of, treatment of intra- articular fracture of, by closed reduction, with or without treatment of fibular fracture (Assist.) (Anaes.)	$854.80
47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Assist.) (Anaes.)	$989.10
47573	Tibia, shaft of, treatment of intra- articular fracture of, by open reduction, with or without treatment of fibular fracture (Assist.) (Anaes.)	$1,305.40
47576	Fibula, treatment of fracture of (Anaes.)	$178.60
47579	Patella, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)	$253.30
47582	Patella, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Assist.) (Anaes.)	$654.00
47585	Patella, treatment of fracture of, by internal fixation (Assist.) (Anaes.)	$827.80
47588	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Assist.) (Anaes.)	$2,388.90
47591	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Assist.) (Anaes.)	$2,904.00
47594	Ankle joint, treatment of fracture of, not being a service to which item 47597 applies (Anaes.)	$342.60
47597	Ankle joint, treatment of fracture of, by closed reduction (Anaes.)	$593.70

47600	Ankle joint, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Assist.) (Anaes.)	$850.50
47603	Ankle joint, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Assist.) (Anaes.)	$1,084.70
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.)	$372.80
47609	Calcaneum or talus, treatment of fracture of, by closed reduction, with or without dislocation (Assist.) (Anaes.)	$649.00
47612	Calcaneum or talus, treatment of intra- articular fracture of, by closed reduction, with or without dislocation (Assist.) (Anaes.)	$814.30
47615	Calcaneum or talus, treatment of fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.)	$854.80
47618	Calcaneum or talus, treatment of intra- articular fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.)	$1,226.50
47621	Tarso-metatarsal, treatment of intra- articular fracture of, by closed reduction, with or without dislocation (Assist.) (Anaes.)	$748.90
47624	Tarso-metatarsal, treatment of fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.)	$1,110.10
47627	Tarsus (excluding calcaneum or talus), treatment of fracture of (Anaes.)	$253.30
47630	Tarsus (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.)	$640.40
47633	Metatarsal, 1 of, treatment of fracture of (Anaes.)	$178.60
47636	Metatarsal, 1 of, treatment of fracture of, by closed reduction (Anaes.)	$268.20
47639	Metatarsal, 1 of, treatment of fracture of, by open reduction (Anaes.)	$494.00
47642	Metatarsals, 2 of, treatment of fracture of (Anaes.)	$238.70
47645	Metatarsals, 2 of, treatment of fracture of, by closed reduction (Anaes.)	$408.60
47648	Metatarsals, 2 of, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$609.10
47651	Metatarsals, 3 or more of, treatment of fracture of (Anaes.)	$372.80
47654	Metatarsals, 3 or more of, treatment of fracture of, by closed reduction (Assist.) (Anaes.)	$694.80
47657	Metatarsals, 3 or more of, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$876.80
47663	Phalanx of great toe, treatment of fracture of, by closed reduction (Anaes.)	$223.60
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.)	$186.60
47678	Phalanx of toe (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.)	$309.50
47681	Spine (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance	$77.50
47684	Spine, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Assist.) (Anaes.)	$1,463.20
47687	Spine, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers or halo, and including up to 14 days post-operative care (Assist.)	$2,395.70
47690	Spine, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation	$1,866.40

	(Assist.) (Anaes.)	
47693	Spine, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.)	$2,395.70
47696	Spine, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital (Assist.) (Anaes.)	$684.80
47699	Spine, treatment of fracture, dislocation or fracture-dislocation without cord involvement requiring open reduction with or without internal fixation (Assist.) (Anaes.)	$2,859.30
47702	Spine, treatment of fracture, dislocation or fracture-dislocation with cord involvement requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Assist.) (Anaes.)	$3,481.80
47703	Skull, treatment of fracture of, each attendance	$82.80
47705	Skull calipers, insertion of, as an independent procedure (Assist.) (Anaes.)	$710.00
47708	Plaster jacket, application of, as an independent procedure (Anaes.)	$342.60
47711	Halo, application of, as an independent procedure (Assist.) (Anaes.)	$726.90
47714	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)	$437.60
47717	Halo-thoracic traction - application of both halo and thoracic jacket (Assist.) (Anaes.)	$989.20
47720	Halo-femoral traction, as an independent procedure (Assist.) (Anaes.)	$1,052.60
47723	Halo-femoral traction in conjunction with a major spine operation (Assist.) (Anaes.)	$970.50
47726	Bone graft, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.)	$355.00
47729	Bone graft, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.)	$590.00
47732	Vascularised pedicle bone graft, harvesting of, in conjunction with another service (Assist.) (Anaes.)	$857.20
47735	Nasal bones, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance	$92.10
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$600.40
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (Assist.) (Anaes.)	$1,066.10
47753	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Assist.) (Anaes.)	$1,020.00
47756	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Assist.) (Anaes.)	$952.50
47762	Zygomatic bone, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)	$562.40
47765	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Assist.) (Anaes.)	$938.90
47768	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Assist.) (Anaes.)	$1,200.00
47771	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Assist.) (Anaes.)	$1,380.00
47774	Maxilla, treatment of fracture of, requiring open operation (Assist.) (Anaes.)	$790.90
47777	Mandible, treatment of fracture of, requiring open reduction (Assist.) (Anaes.)	$689.50

47780	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Assist.) (Anaes.)	$896.40
47783	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Assist.) (Anaes.)	$896.40
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Assist.) (Anaes.)	$1,800.00
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Assist.) (Anaes.)	$1,416.00
47900	Bone cyst, injection into or aspiration of (Anaes.)	$304.40
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.)	$89.40
47906	Digital nail of toe, removal of, in the operating theatre of a hospital (Anaes.)	$203.80
47912	Pulp space infection, paronychia of foot, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.)	$89.40
47915	Ingrowing nail of toe, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)	$282.30
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.)	$134.80
47918	Ingrowing toenail, radical excision of nailbed (Anaes.)	$424.00
47920	Bone growth stimulator, insertion of (Assist.) (Anaes.)	$685.40
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.)	$69.60
47927	Buried wire, pin or screw, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.)	$288.20
47930	Plate, rod or nail and associated wires, pins or screws, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Assist.) (Anaes.)	$554.10
47933	Small exostosis (not more than 20mm of growth above bone), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.)	$444.40
47936	Large exostosis (greater than 20mm growth above bone), excision of (Assist.) (Anaes.)	$545.00
47948	External fixation, removal of, in the operating theatre of a hospital (Anaes.)	$299.10
47951	External fixation, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	$332.50
47954	Tendon, repair of, as an independent procedure (Assist.) (Anaes.)	$792.40
47957	Tendon, large, lengthening of, as an independent procedure (Assist.) (Anaes.)	$637.80
47960	Tenotomy, subcutaneous, not being a service to which another item in this Group applies (Anaes.)	$280.00
47963	Tenotomy, open, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.)	$509.70
47966	Tendon or ligament transfer, as an independent procedure (Assist.) (Anaes.)	$957.90

47969	Tenosynovectomy, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$577.40
47972	Tendon sheath, open operation for teno- vaginitis, not being a service to which another item in this Group applies (Anaes.)	$478.90
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Assist.) (Anaes.)	$798.00
47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.)	$558.10
47981	Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, not being a service to which another item applies (Anaes.)	$371.30
47982	Forage (Drill decompression), of neck or head of femur, or both (Assist.) (Anaes.)	$709.60
48200	Femur, bone graft to (Assist.) (Anaes.)	$1,365.80
48203	Femur, bone graft to, with internal fixation (Assist.) (Anaes.)	$1,653.80
48206	Tibia, bone graft to (Assist.) (Anaes.)	$1,102.20
48209	Tibia, bone graft to, with internal fixation (Assist.) (Anaes.)	$1,320.70
48212	Humerus, bone graft to (Assist.) (Anaes.)	$1,044.60
48215	Humerus, bone graft to, with internal fixation (Assist.) (Anaes.)	$1,324.10
48218	Radius or ulna, bone graft to (Assist.) (Anaes.)	$1,032.20
48221	Radius and ulna, bone graft to, with internal fixation of 1 or both bones (Assist.) (Anaes.)	$1,422.90
48224	Radius or ulna, bone graft to (Assist.) (Anaes.)	$722.00
48227	Radius or ulna, bone graft to, with internal fixation of 1 or both bones (Assist.) (Anaes.)	$1,026.40
48230	Scaphoid, bone graft to, for non-union (Assist.) (Anaes.)	$976.00
48233	Scaphoid, bone graft to, for non-union, with internal fixation (Assist.) (Anaes.)	$1,272.80
48236	Scaphoid, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Assist.) (Anaes.)	$1,448.60
48239	Bone graft, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$882.00
48242	Bone graft, with internal fixation, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$1,378.30
48400	Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Assist.) (Anaes.)	$661.50
48403	Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,075.00
48406	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$680.80
48409	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,113.70
48412	Humerus, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,174.50
48415	Humerus, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,473.00

48418	Tibia, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,162.80
48421	Tibia, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,807.10
48424	Femur or pelvis, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,718.10
48427	Femur or pelvis, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.)	$1,788.90
48500	Femur, epiphysiodesis of (Assist.) (Anaes.)	$606.90
48503	Tibia and fibula, epiphysiodesis of (Assist.) (Anaes.)	$603.20
48506	Femur, tibia and fibula, epiphysiodesis of (Assist.) (Anaes.)	$890.00
48509	Epiphysiodesis, staple arrest of hemiepiphysis (Anaes.)	$372.80
48512	Epiphysiolysis, operation to prevent closure of plate (Assist.) (Anaes.)	$1,625.20
48600	Spine, manipulation of, performed in the operating theatre of a hospital (Anaes.)	$172.70
48603	Spine, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.)	$346.70
48606	Scoliosis or Kyphosis, spinal fusion for (without instrumentation) (Assist.) (Anaes.)	$3,305.00
48612	Scoliosis, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Assist.) (Anaes.)	$5,391.60
48613	Scoliosis or kyphosis, spinal fusion for, using segmental instrumentation, reconstruction using separate anterior and posterior approaches (Assist.) (Anaes.)	$6,430.10
48615	Scoliosis, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Assist.) (Anaes.)	$897.80
48618	Scoliosis, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Assist.) (Anaes.)	$4,560.40
48621	Scoliosis, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Assist.) (Anaes.)	$4,015.00
48624	Scoliosis, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Assist.) (Anaes.)	$4,122.50
48627	Scoliosis, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Assist.) (Anaes.)	$5,098.70
48630	Scoliosis, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Assist.) (Anaes.)	$4,856.00
48632	Scoliosis, congenital, vertebral resection and fusion for (Assist.) (Anaes.)	$2,470.90
48636	Percutaneous lumbar partial or total discectomy, 1 or more levels, not being a service associated with intradiscal electrothermal annuloplasty (Assist.) (Anaes.)	$1,470.30
48639	Vertebral body, total or subtotal excision of, including bone grafting or other form of fixation (Assist.) (Anaes.)	$3,177.30
48640	Vertebral body, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Assist.) (Anaes.)	$6,426.60
48642	Spine, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Assist.) (Anaes.)	$1,832.40

48645	Spine, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Assist.) (Anaes.)	$2,346.60
48648	Spine, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Assist.) (Anaes.)	$2,447.10
48651	Spine, bone graft to, (postero-lateral fusion) - more than 2 levels (Assist.) (Anaes.)	$3,022.10
48654	Spinal fusion (posterior interbody), with partial or total laminectomy, 1 level (Assist.) (Anaes.)	$2,659.30
48657	Spinal fusion (posterior interbody), with partial or total laminectomy, more than 1 level (Assist.) (Anaes.)	$3,660.00
48660	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - 1 level, not being a service associated with artificial intervertebral total disc replacement (Assist.) (Anaes.)	$2,558.40
48663	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Assist.) (Anaes.)	$1,482.70
48666	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.)	$1,087.60
48669	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level, not being a service associated with artificial intervertebral total disc replacement (Assist.) (Anaes.)	$3,384.50
48672	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Assist.) (Anaes.)	$2,517.20
48675	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.)	$1,194.40
48678	Spine, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Assist.) (Anaes.)	$1,415.00
48681	Spine, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Assist.) (Anaes.)	$1,709.30
48684	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels, not being a service associated with artificial intervertebral total disc replacement (Assist.) (Anaes.)	$2,281.70
48687	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Assist.) (Anaes.)	$3,175.90
48690	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Assist.) (Anaes.)	$3,281.40
48691	Lumbar artificial intervertebral total disc replacement including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (Assist.) (Anaes.)	$4,625.00
48692	Lumbar artificial intervertebral total disc replacement including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (where an assisting surgeon performs the approach) - principal surgeon (Assist.) (Anaes.)	$3,115.00
48693	Lumbar artificial intervertebral total disc replacement including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) (Anaes.)	$1,068.80

48694	Cervical artificial intervertebral total disc replacement, at one level only, including removal of disc, 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; other than a service associated with item 40300 or 40301 (Assist.) (Anaes.)	$1,661.50
48900	Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Assist.) (Anaes.)	$492.70
48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Assist.) (Anaes.)	$1,130.60
48906	Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Assist.) (Anaes.)	$1,034.00
48909	Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Assist.) (Anaes.)	$1,686.20
48912	Shoulder, arthrotomy of (Assist.) (Anaes.)	$600.70
48915	Shoulder, hemi-arthroplasty of (Assist.) (Anaes.)	$1,508.50
48918	Shoulder, total replacement arthroplasty of, including any associated rotator cuff repair (Assist.) (Anaes.)	$3,127.70
48921	Shoulder, total replacement arthroplasty, revision of (Assist.) (Anaes.)	$2,819.60
48924	Shoulder, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Assist.) (Anaes.)	$3,601.90
48927	Shoulder prosthesis, removal of (Assist.) (Anaes.)	$580.90
48930	Shoulder, stabilisation procedure for recurrent anterior or posterior dislocation (Assist.) (Anaes.)	$1,700.80
48933	Shoulder, stabilisation procedure for multi-directional instability, anterior or posterior (or both) repair when performed (Assist.) (Anaes.)	$2,009.00
48936	Shoulder, synovectomy of, as an independent procedure (Assist.) (Anaes.)	$1,438.60
48939	Shoulder, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$2,225.00
48942	Shoulder, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Assist.) (Anaes.)	$2,557.40
48945	Shoulder, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)	$531.20
48948	Shoulder, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)	$1,325.60
48951	Shoulder, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)	$1,705.20
48954	Shoulder, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)	$1,780.60
48957	Shoulder, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)	$2,237.80

48960	Shoulder, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Assist.) (Anaes.)	$1,977.70
49100	Elbow, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Assist.) (Anaes.)	$666.10
49103	Elbow, ligamentous stabilisation of (Assist.) (Anaes.)	$1,443.10
49106	Elbow, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$1,709.30
49109	Elbow, total synovectomy of (Assist.) (Anaes.)	$1,488.20
49112	Elbow, silastic or other replacement of radial head (Assist.) (Anaes.)	$1,415.70
49115	Elbow, total joint replacement of (Assist.) (Anaes.)	$2,687.70
49116	Elbow, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.)	$2,611.60
49117	Elbow, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Assist.) (Anaes.)	$3,646.70
49118	Elbow, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Assist.) (Anaes.)	$556.10
49121	Elbow, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Assist.) (Anaes.)	$1,280.40
49200	Wrist, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Assist.) (Anaes.)	$1,593.90
49203	Wrist, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Assist.) (Anaes.)	$1,239.70
49206	Wrist, proximal carpectomy of, including styloidectomy when performed (Assist.) (Anaes.)	$1,142.20
49209	Wrist, total replacement arthroplasty of (Assist.) (Anaes.)	$1,610.60
49210	Wrist, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.)	$1,680.20
49211	Wrist, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Assist.) (Anaes.)	$2,249.80
49212	Wrist, arthrotomy of (Anaes.)	$466.10
49215	Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Assist.) (Anaes.)	$1,280.00
49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Assist.) (Anaes.)	$637.50
49221	Wrist, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body, release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Assist.) (Anaes.)	$1,343.50
49224	Wrist, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, not being a service associated with any other arthroscopic procedure of the wrist (Assist.) (Anaes.)	$1,418.20
49227	Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Assist.) (Anaes.)	$1,444.40
49300	Sacroiliac joint arthrodesis of (Assist.) (Anaes.)	$1,300.00

49303	Hip, arthrotomy of, including lavage, drainage or biopsy when performed (Assist.) (Anaes.)	$1,008.60
49306	Hip arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$2,039.80
49309	Hip, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Assist.) (Anaes.)	$1,550.10
49312	Hip, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Assist.) (Anaes.)	$1,709.30
49315	Hip, arthroplasty of, unipolar or bipolar (Assist.) (Anaes.)	$1,564.40
49318	Hip, total replacement arthroplasty of, including minor bone grafting (Assist.) (Anaes.)	$2,730.40
49319	Hip, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Assist.) (Anaes.)	$5,233.80
49321	Hip, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Assist.) (Anaes.)	$2,986.60
49324	Hip, total replacement arthroplasty of, revision procedure including removal of prosthesis (Assist.) (Anaes.)	$3,413.50
49327	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Assist.) (Anaes.)	$4,072.40
49330	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Assist.) (Anaes.)	$4,295.70
49333	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Assist.) (Anaes.)	$4,654.90
49336	Hip, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Assist.) (Anaes.)	$618.90
49339	Hip, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Assist.) (Anaes.)	$5,038.70
49342	Hip, revision total replacement of, requiring anatomic specific allograft of acetabulum (Assist.) (Anaes.)	$5,721.10
49345	Hip, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Assist.) (Anaes.)	$5,977.70
49346	Hip, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Assist.) (Anaes.)	$1,574.50
49360	Hip, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Assist.) (Anaes.)	$669.40
49363	Hip, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Assist.) (Anaes.)	$748.40
49366	Hip, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the hip (Assist.) (Anaes.)	$1,515.30
49500	Knee, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Assist.) (Anaes.)	$723.10
49503	Knee, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 1 procedure (Assist.) (Anaes.)	$953.00
49506	Knee, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group	$1,383.40

	applies) - any 2 or more procedures (Assist.) (Anaes.)	
49509	Knee, total synovectomy or arthrodesis with synovectomy if performed (Assist.) (Anaes.)	$1,362.80
49512	Knee, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Assist.) (Anaes.)	$2,054.30
49515	Knee, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Assist.) (Anaes.)	$1,833.50
49517	Knee, hemiarthroplasty of (Assist.) (Anaes.)	$2,625.20
49518	Knee, total replacement arthroplasty of (Assist.) (Anaes.)	$2,727.00
49519	Knee, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Assist.) (Anaes.)	$5,145.30
49521	Knee, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Assist.) (Anaes.)	$2,950.50
49524	Knee, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Assist.) (Anaes.)	$3,554.10
49527	Knee, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.)	$3,052.40
49530	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Assist.) (Anaes.)	$3,579.00
49533	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Assist.) (Anaes.)	$4,244.30
49534	Knee, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Assist.) (Anaes.)	$1,140.00
49536	Knee, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.)	$1,860.50
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 (Assist.) (Anaes.)	$2,107.90
49542	Knee, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.)	$2,822.50
49545	Knee, revision arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$1,192.00
49548	Knee, revision of patello-femoral stabilisation (Assist.) (Anaes.)	$1,928.60
49551	Knee, revision of procedures to which item 49536, 49539 or 49542 applies (Assist.) (Anaes.)	$2,821.20
49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur (Assist.) (Anaes.)	$3,447.80
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 (Assist.) (Anaes.)	$573.70
49558	Knee, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chrondroplasty - not associated with any other arthroscopic procedure of the knee region	$532.40

	(Assist.) (Anaes.)	
49559	Knee, arthroscopic surgery of, involving chrondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.)	$825.30
49560	Knee, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.)	$1,145.60
49561	Knee, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.)	$1,369.20
49562	Knee, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.)	$1,500.10
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 (Assist.) (Anaes.)	$1,622.40
49564	Knee, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.)	$1,906.90
49566	Knee, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.)	$1,754.70
49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Assist.) (Anaes.)	$1,394.00
49700	Ankle, diagnostic arthroscopy of, including biopsy (Assist.) (Anaes.)	$552.40
49703	Ankle, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Assist.) (Anaes.)	$1,332.20
49706	Ankle, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Assist.) (Anaes.)	$700.40
49709	Ankle, ligamentous stabilisation of (Assist.) (Anaes.)	$1,514.10
49712	Ankle, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$1,600.00
49715	Ankle, total joint replacement of (Assist.) (Anaes.)	$2,268.30
49716	Ankle, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.)	$2,472.60
49717	Ankle, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Assist.) (Anaes.)	$3,811.90
49718	Ankle, Achilles' tendon or other major tendon, repair of (Assist.) (Anaes.)	$828.90
49721	Ankle, Achilles' tendon rupture managed by non-operative treatment	$423.70
49724	Ankle, Achilles' tendon, secondary repair or reconstruction of (Assist.) (Anaes.)	$1,655.00
49727	Ankle, Achilles' tendon, operation for lengthening (Assist.) (Anaes.)	$630.80
49728	Ankle, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Assist.) (Anaes.)	$985.60
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 (Assist.) (Anaes.)	$897.00
49815	Foot, triple arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$1,664.00
49818	Foot, excision of calcaneal spur (Assist.) (Anaes.)	$654.70
49821	Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Assist.) (Anaes.)	$856.90
49824	Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Assist.) (Anaes.)	$1,371.00
49827	Foot, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Assist.) (Anaes.)	$948.50
49830	Foot, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Assist.) (Anaes.)	$1,809.00
49833	Foot, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Assist.) (Anaes.)	$1,083.60
49836	Foot, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Assist.) (Anaes.)	$1,992.30
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 (Assist.) (Anaes.)	$1,272.70
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 (Assist.) (Anaes.)	$2,174.00
49839	Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Assist.) (Anaes.)	$1,136.50
49842	Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Assist.) (Anaes.)	$1,981.00
49845	Foot, arthrodesis of, first metatarso- phalangeal joint, with synovectomy if performed (Assist.) (Anaes.)	$1,039.90
49848	Foot, correction of claw or hammer toe (Anaes.)	$321.10
49851	Foot, correction of claw or hammer toe with internal fixation (Anaes.)	$467.50
49854	Foot, radical plantar fasciotomy or fasciectomy of (Assist.) (Anaes.)	$721.10
49857	Foot, metatarso-phalangeal joint replacement (Assist.) (Anaes.)	$838.40
49860	Foot, synovectomy of metatarso- phalangeal joint, single joint (Assist.) (Anaes.)	$581.90
49863	Foot, synovectomy of metatarso- phalangeal joint, 2 or more joints (Assist.) (Anaes.)	$824.90
49866	Foot, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Assist.) (Anaes.)	$656.30
49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation - each attendance (Anaes.)	$101.90
50100	Joint, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Assist.) (Anaes.)	$494.50

50102	Joint, arthroscopic surgery of, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$1,173.10
50103	Joint, arthrotomy of, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$649.00
50104	Joint, synovectomy of, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$635.10
50106	Joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$934.10
50109	Joint, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Assist.) (Anaes.)	$966.20
50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$670.50
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.)	$262.30
50118	Subtalar joint, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.)	$932.30
50121	Greater Trochanter, transplantation of ileopsoas tendon to (Assist.) (Anaes.)	$1,913.40
50127	Joint or joints, arthroplasty of, by any technique not being a service to which another item applies (Assist.) (Anaes.)	$1,332.50
50130	Joint or joints, application of external fixator to, other than for treatment of fractures (Assist.) (Anaes.)	$731.10
50200	Aggressive or potentially malignant bone or deep soft tissue tumour, biopsy of (not including aftercare) (Anaes.)	$339.70
50201	Aggressive or potentially malignant bone or deep soft tissue tumour, involving neurovascular structures, open biopsy of (not including aftercare) (Assist.) (Anaes.)	$659.30
50203	Bone or malignant deep soft tissue tumour, lesional or marginal excision of (Assist.) (Anaes.)	$854.90
50206	Bone tumour, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.)	$1,220.30
50209	Bone tumour, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.)	$1,426.60
50212	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Assist.) (Anaes.)	$3,039.30
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) (Assist.) (Anaes.)	$3,684.10
50218	Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Assist.) (Anaes.)	$4,919.50
50221	Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of (Assist.) (Anaes.)	$4,783.00
50224	Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Assist.) (Anaes.)	$5,069.00
50227	Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Assist.) (Anaes.)	$5,310.80

50230	Benign tumour, resection of, requiring anatomic specific allograft, with or without internal fixation (Assist.) (Anaes.)	$2,814.50
50233	Malignant tumour, amputation for, hemipelvectomy or interscapulo-thoracic (Assist.) (Anaes.)	$3,854.60
50236	Malignant tumour, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Assist.) (Anaes.)	$2,695.50
50239	Malignant tumour, amputation for, not being a service to which another item in this Group applies (Assist.) (Anaes.)	$2,024.80
50300	Joint deformity, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Assist.) (Anaes.)	$2,075.30
50303	Limb lengthening, 5cm or less, by gradual distraction, with application of an external fixator or intra- medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Assist.) (Anaes.)	$2,837.30
50306	Limb lengthening, where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Assist.) (Anaes.)	$4,427.10
50309	Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Assist.) (Anaes.)	$555.00
50312	Ankle, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Assist.) (Anaes.)	$1,257.50
50315	Talipes equinovarus, posterior release of (Assist.) (Anaes.)	$1,265.60
50318	Talipes equinovarus, medial release of (Assist.) (Anaes.)	$1,097.10
50321	Talipes equinovarus, combined postero- medial release of (Assist.) (Anaes.)	$1,672.50
50324	Talipes equinovarus, combined postero- medial release of, revision procedure (Assist.) (Anaes.)	$2,095.30
50327	Talipes equinovarus, bilateral procedures (Assist.) (Anaes.)	$2,556.00
50330	Talipes equinovarus, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.)	$504.00
50333	Tarsal coalition, excision of, with interposition of muscle, fat graft or similar graft (Assist.) (Anaes.)	$1,238.50
50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (Assist.) (Anaes.)	$1,459.20
50339	Foot and ankle, tibialis anterior tendon (split or whole) transfer to lateral column (Assist.) (Anaes.)	$1,007.80
50342	Foot and ankle, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Assist.) (Anaes.)	$1,205.10
50345	Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Assist.) (Anaes.)	$737.90
50348	Knee, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.)	$470.50
50349	Hip, congenital dislocation of, treatment of, by closed reduction (Anaes.)	$506.70
50351	Hip, developmental dislocation of, open reduction of (Assist.) (Anaes.)	$2,527.60
50352	Hip, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.)	$101.90

50353	Hip spica, initial application of, for congenital dislocation of hip (excluding aftercare) (Assist.) (Anaes.)	$561.40
50354	Tibia, pseudarthrosis of, congenital, resection and internal fixation (Assist.) (Anaes.)	$2,073.20
50357	Knee, leg or thigh, rectus femoris tendon transfer or medial or lateral hamstring tendon transfer (Assist.) (Anaes.)	$1,242.20
50360	Knee, leg or thigh, combined medial and lateral hamstring tendon transfer (Assist.) (Anaes.)	$1,380.50
50363	Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Assist.) (Anaes.)	$896.60
50366	Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Assist.) (Anaes.)	$1,564.10
50369	Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Assist.) (Anaes.)	$1,177.50
50372	Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Assist.) (Anaes.)	$1,810.20
50375	Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Assist.) (Anaes.)	$1,155.00
50378	Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Assist.) (Anaes.)	$1,940.40
50381	Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Assist.) (Anaes.)	$1,165.80
50384	Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Assist.) (Anaes.)	$2,064.70
50387	Hip, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer or adductors to ischium (Assist.) (Anaes.)	$1,031.10
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.)	$427.70
50393	Pelvis, bone graft or shelf procedures for acetabular dysplasia (Assist.) (Anaes.)	$1,516.80
50394	Acetabular dysplasia, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Assist.) (Anaes.)	$5,019.60
50396	Hand, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Assist.) (Anaes.)	$915.40
50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (Assist.) (Anaes.)	$1,459.20
50402	Torticollis, bipolar release of sternocleidomastoid muscle and associated soft tissue (Assist.) (Anaes.)	$762.00
50405	Elbow, flexorplasty, or tendon transfer to restore elbow function (Assist.) (Anaes.)	$1,200.70
50408	Shoulder, congenital or developmental dislocation, open reduction of (Assist.) (Anaes.)	$1,579.70
50411	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Assist.) (Anaes.)	$2,073.20
50414	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Assist.) (Anaes.)	$2,797.30
50417	Lower limb deficiency, treatment of congenital deficiency of the tibia by reconstruction of	$2,073.20

	the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Assist.) (Anaes.)	
50420	Patella, congenital dislocation of, reconstruction of the quadriceps (Assist.) (Anaes.)	$1,711.40
50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Assist.) (Anaes.)	$2,285.90
50426	Diaphyseal aclasia, removal of lesion or lesions from bone - 1 approach (Assist.) (Anaes.)	$986.70
50450	Unilateral single event multilevel surgery for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of femoral torsion by rotational osteotomy of the femur. Correction of tibial torsion by rotational osteotomy of the tibia. Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.)	$1,931.70
50451	Unilateral single event multilevel surgery for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.)	$1,931.70
50455	Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.)	$2,187.60
50456	Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.)	$2,187.60
50460	Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.)	$3,266.00
50461	Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.)	$3,266.00
50465	Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of abnormal	$4,600.30

	torsion of the femur by rotational osteotomy with internal fixation. Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.)	
50466	Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.)	$4,600.30
50470	Bilateral single event multilevel surgery for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.)	$5,834.30
50471	Bilateral single event multilevel surgery for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.)	$5,834.30
50475	Single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.)	$6,732.20
50476	Single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. (d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.)	$6,732.20
50500	Radius or ulna, distal end of, with open growth plate, treatment of fracture of, by closed reduction (Anaes.)	$790.00
50504	Radius or ulna, distal end of, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$583.90

50508	Radius, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)	$842.30
50512	Radius, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Assist.) (Anaes.)	$1,013.10
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.)	$613.00
50520	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$1,169.80
50524	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Assist.) (Anaes.)	$646.50
50528	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Assist.) (Anaes.)	$1,573.60
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.)	$1,640.00
50536	Radius and ulna, shafts of, with open growth plates, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$1,383.30
50540	Olecranon, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$907.90
50544	Radius, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.)	$417.20
50548	Radius, with open growth plate, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Assist.) (Anaes.)	$834.50
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.)	$833.20
50556	Humerus, proximal, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.)	$1,103.30
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.)	$750.80
50564	Humerus, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (Assist.) (Anaes.)	$1,001.20
50568	Humhumerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	$953.30
50572	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Assist.) (Anaes.)	$1,322.70
50576	Femur, with open growth plate, treatment of fracture of, by closed reduction or traction (Assist.) (Anaes.)	$1,533.80
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 (Assist.) (Anaes.)	$1,049.10
50584	Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Assist.) (Anaes.)	$1,377.50

50588	Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (Assist.) (Anaes.)	$1,324.50
50600	Scoliosis or kyphosis, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Assist.) (Anaes.)	$684.40
50604	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (Assist.) (Anaes.)	$2,905.00
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 48642 to 48675 applies (Assist.) (Anaes.)	$6,995.00
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 48642 to 48675 applies (Assist.) (Anaes.)	$8,985.00
50616	Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Assist.) (Anaes.)	$1,132.70
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 48642 to 48675 applies (Assist.) (Anaes.)	$5,901.70
50624	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Assist.) (Anaes.)	$6,213.40
50628	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Assist.) (Anaes.)	$7,697.40
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 48642 to 48675 applies (Assist.) (Anaes.)	$6,682.20
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 48642 to 48675 applies (Assist.) (Anaes.)	$6,225.70
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 48642 to 48675 applies (Assist.) (Anaes.)	$3,441.50
50644	Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Assist.) (Anaes.)	$4,242.10
50650	Hip dysplasia or dislocation, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.)	$653.00
50654	Hip dysplasia or dislocation, in a child, application or reapplication of a hip spica, including examination of the hip (Assist.) (Anaes.)	$782.00
50658	Hip dysplasia or dislocation, in a child, examination and manipulation of the hip under anaesthesia (Anaes.)	$363.80

Radiofrequency ablation

50950	Nonresectable hepatocellular carcinoma, destruction of, by percutaneous radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50952 applies (Anaes.)	$1,351.00
50952	Nonresectable hepatocellular carcinoma, destruction of, by open or laparoscopic radiofrequency ablation, where a multi-disciplinary team has assessed that percutaneous radiofrequency ablation cannot be performed or is not practical because of one or more of the following clinical circumstances:- percutaneous access cannot be achieved;- vital organs/tissues are at risk of damage from the percutaneous rfa procedure; or- resection of one part of the liver is possible however there is at least one primary liver tumour in a non-resectable region of the liver which is suitable for radiofrequency ablation, including any	$1,467.90

	associated imaging services, not being a service associated with a service to which item 30419 or 50950 applies (Anaes.)	

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 $912.20 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 $912.20.	$142.70
51303	Assistance at any operation identified by the word "Assist" for which the fee exceeds $912.20 or at a series of operations identified by the word "Assist" for which the aggregate fee exceeds $912.20. Derived fee: One fifth of the established fee for the operation or combination of operations.	DF
51306	Assistance at a delivery 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	$433.00
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	$263.00

GROUP O1 - CONSULTATIONS

51700	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner in the practice of oraland maxillofacial surgery, at consulting rooms, hospital or residential aged care facility if the patient is referred to him or her	$137.90
51703	Professional attendance by an approved dental practitioner in the practice of Oral and Maxillofacial Surgery, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility if the patient is referred to him or her	$69.40

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	$142.70

	$912.20 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 $912.20.	
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 $912.20 or at a series of combination of operations identified by the word "Assist" where the aggregate fee exceeds $912.20. Derived fee: One fifth of the established fee for the operation or combination of operations.	DF

GROUP O3 - GENERAL SURGERY

51900	Wound of soft tissue in the oral and maxillofacial region, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.) (Anaes.)	$525.70
51902	Wounds of the oral and maxillofacial region, dressing of, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in groups O3 to O9 applies (Anaes.)	$119.20
51904	Lipectomy - wedge excision of skin or fat -1 excision (Assist.) (Anaes.)	$834.40
51906	Lipectomy - wedge excision of skin or fat - 2 or more excisions (Assist.) (Anaes.)	$1,094.70
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.)	$133.00
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.)	$189.50
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.)	$189.50
52009	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7 cm long), involving deeper tissue (Anaes.)	$367.50
52010	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Assist.) (Anaes.)	$569.60
52012	Superficial foreign body, removal of, as an independent procedure (Anaes.)	$99.90
52015	Subcutaneous foreign body, removal of, requiring incision and suture, as an independent procedure (Anaes.)	$409.50
52018	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Assist.) (Anaes.)	$446.10
52021	Aspiration biopsy of 1 or more jaw cysts as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.)	$69.60
52024	Biopsy of skin or mucous membrane, as an independent procedure (Anaes.)	$162.20
52025	Lymph node of neck, biopsy of (Anaes.)	$290.90
52027	Biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure and not being a service to which item 52025 applies (Anaes.)	$281.00
52030	Sinus, excision of, involving superficial tissue only (Anaes.)	$145.20
52033	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$290.90
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.)	$1,079.60

52036	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, if the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.)	$252.90
52039	Tumours, cysts, ulcers or scars (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, if the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than10 lesions ((Assist.) (Anaes.)	$525.70
52042	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	$336.10
52045	Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.)	$398.30
52048	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in groups O3 to O9 applies (Assist.) (Anaes.)	$657.20
52051	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Assist.) (Anaes.)	$811.30
52054	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Assist.) (Anaes.)	$973.20
52055	Haematoma, small abscess or cellulitis in the oral and maxillofacial region, not requiring admission to a hospital, incision with drainage of (excluding after- care)	$44.10
52056	Haematoma in the oral and maxillofacial region, aspiration of (Anaes.)	$44.10
52057	Large haematoma, large abscess, carbuncle, cellulitis orsimilar lesion in the oral and maxillofacial region, incision with drainage of (excluding after-care) (Anaes.)	$262.80
52058	Percutaneous drainage of deep abscess in the oral and maxillofacial region, using interventional imaging techniques - but not including imaging (Anaes.)	$383.30
52059	Abscess in the oral and maxillofacial region drainage tube, exchange of using interventional imaging techniques - but not including imaging (Anaes.)	$1,137.80
52060	Muscle in the oral and maxillofacial region, excision of (Anaes.)	$325.80
52061	Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (Anaes.)	$354.00
52062	Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (Assist.) (Anaes.)	$467.90
52063	Bone tumour in the oral and maxillofacial region, innocent, excision of, not being a service to which another item in groups O3 to O9 applies (Assist.) (Anaes.)	$647.10
52064	Bone cyst in the oral and maxillofacial region, injection into or aspiration of (Anaes.)	$287.40
52066	Submandibular gland, extirpation of (Assist.) (Anaes.)	$1,303.70
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.)	$236.90

52075	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$326.80
52078	Tongue, partial excision of (Assist.) (Anaes.)	$535.40
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.)	$378.70
52090	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Assist.) (Anaes.)	$574.70
52092	Operation on skull for osteomyelitis (Assist.) (Anaes.)	$735.10
52094	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 52092 (Assist.) (Anaes.)	$1,224.40
52095	Bone growth stimulator in the oral and maxillofacial region, insertion of ((Assist.) (Anaes.)	$868.10
52096	Orthopaedic pin or wire, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.)	$346.60
52097	External fixation in the oral and maxillofacial region, removal of, in the operating theatre of a hospital (Anaes.)	$287.70
52098	External fixation in the oral and maxillofacial region, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	$345.30
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.)	$227.70
52102	Buried wire, pin or screw, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, if undertaken in the operating theatre of a hospital, per bone (Anaes.)	$256.50
52105	Plate, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Assist.) (Anaes.)	$483.40
52106	Arch bars, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia if undertaken in the operating theatre of a hospital (Anaes.)	$336.20
52108	Lip, full thickness wedge excision of, with repair by direct sutures (Assist.) (Anaes.)	$525.70
52111	Vermilionectomy (Assist.) (Anaes.)	$752.70
52114	Mandible or maxilla, segmental resection of, for tumours or cysts (Assist.) (Anaes.)	$1,115.40
52117	Mandible, including lower border, or maxilla, sub-total resection of (Assist.) (Anaes.)	$1,161.20
52120	Mandible, hemimandiblectomy of, including condylectomy where performed (Assist.) (Anaes.)	$3,517.20
52122	Mandible, hemi-mandibular reconstruction of, or maxilla reconstruction of, with bone graft, plate, tray or alloplast, not being a service associated with a service to which item 52123 applies (Assist.) (Anaes.)	$3,517.20
52123	Mandible, total resection of both sides, including condylectomies where performed (Assist.) (Anaes.)	$1,482.10
52126	Maxilla, total resection of (Assist.) (Anaes.)	$1,424.90

52129	Maxilla, total resection of both maxillae (Assist.) (Anaes.)	$1,907.50
52130	Bone graft in the oral and maxillofacial region, not being a service to which another item in groups O3 to O9applies (Assist.) (Anaes.)	$713.60
52131	bone graft with internal fixation, not being a service to which an item in the range (a) 51900 to 52186; or(b) 52303 to 53460 applies (Assist.) (Anaes.)	$1,638.40
52132	Tracheostomy (Anaes.)	$1,058.20
52133	Cricothyrostomy by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	$144.10
52135	Post-operative or post-nasal haemorrhage, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.)	$232.90
52138	Maxillary artery, ligation of (Assist.) (Anaes.)	$1,420.30
52141	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 52138 applies (Assist.) (Anaes.)	$798.20
52144	Foreign body, deep, removal of using interventional imaging techniques (Assist.) (Anaes.)	$667.00
52147	Duct of major salivary gland, transposition of (Assist.) (Anaes.)	$714.30
52148	Parotid duct, repair of, using micro- surgical techniques (Assist.) (Anaes.)	$1,091.60
52158	Submandibular ducts, relocation of, for surgical control of drooling (Assist.) (Anaes.)	$2,101.80
52180	Aggressive or potentially malignant bone or deep soft tissue tumour in the oral and maxillofacial region, biopsy of (not including after-care) (Anaes.)	$431.40
52182	Bone or malignant deep soft tissue tumour in the oraland maxillofacial region, lesional or marginal excision of (Assist.) (Anaes.)	$702.10
52184	Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any 1 of liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.)	$1,059.90
52186	Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any 2 or more of liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.)	$1,214.80

GROUP O4 - PLASTIC AND RECONSTRUCTIVE

52300	Single-stage local flap, where indicated, repair to 1 defect, with skin or mucosa (Assist.) (Anaes.)	$458.60
52303	Single-stage local flap, where indicated, repair to 1 defect, with buccal pad of fat (Assist.) (Anaes.)	$654.70
52306	Single-stage local flap, where indicated, repair to 1 defect, using temporalis muscle (Assist.) (Anaes.)	$971.70
52309	Free grafting (mucosa or split skin) of a granulating area (Anaes.)	$323.90
52312	Free grafting (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Assist.) (Anaes.)	$535.50
52315	Free grafting, full thickness, to 1 defect (mucosa or skin) (Assist.) (Anaes.)	$966.50
52318	Bone graft, harvesting of, via separate incision, being a service associated with a service to which another item in groups O3 to O9 applies - Autogenous, small quantity (Anaes.)	$402.30
52319	Bone graft, harvesting of, via separate incision, being a service associated with a service to which another item in groups O3 to O9 applies - Autogenous, large quantity (Anaes.)	$731.90

52321	Foreign implant (non-biological), insertion of, for contour reconstruction of pathological deformity, not being a service associated with a service to which item 52624 applies (Assist.) (Anaes.)	$991.10
52324	Direct flap repair, using tongue, first stage (Assist.) (Anaes.)	$1,839.60
52327	Direct flap repair, using tongue, second stage (Anaes.)	$977.90
52330	Palatal defect (oro-nasal fistula), plastic closure of , including services to which item 52300, 52303, 52306 or 52324 applies (Assist.) (Anaes.)	$1,531.20
52333	Cleft palate, primary repair (Assist.) (Anaes.)	$1,237.50
52336	Cleft palate, secondary repair, closure of fistula using local flaps (Assist.) (Anaes.)	$853.70
52337	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Assist.) (Anaes.)	$2,114.10
52339	Cleft palate, secondary repair, lengthening procedure (Assist.) (Anaes.)	$880.80
52342	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$1,614.60
52345	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$2,365.40
52348	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$2,238.30
52351	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$4,502.00
52354	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$2,590.00
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 (Assist.) (Anaes.)	$4,145.70
52360	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$2,719.50
52363	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$5,593.20
52366	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$2,858.50
52369	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$6,464.40
52372	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$3,118.40

52375	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$5,932.30
52378	Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$2,549.00
52379	Face, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Assist.) (Anaes.)	$2,994.50
52380	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.)	$3,616.00
52382	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar- Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.)	$6,628.90
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	$624.20
52424	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) in the oral and maxillofacial region (Assist.) (Anaes.)	$1,461.70
52430	Microvascular repair of the oral and maxillofacial region using microsurgical techniques, with restoration ofcontinuity of artery or vein of distal extremity or digit (Assist.) (Anaes.)	$1,725.40
52440	Cleft lip, unilateral - primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.)	$856.80
52442	Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.)	$1,071.10
52444	Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.)	$1,190.00
52446	Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.)	$1,404.40
52450	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$475.90
52452	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Assist.) (Anaes.)	$788.20
52456	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Assist.) (Anaes.)	$1,309.20
52458	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$475.90
52460	Velo-pharyngeal incompetence, pharyngeal flap for, orpharyngoplasty for (Anaes.)	$1,237.50
52480	Composite graft (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Assist.) (Anaes.)	$794.90
52482	Macrocheilia or macroglossia, operation for (Assist.) (Anaes.)	$764.80
52484	Macrostomia, operation for (Assist.) (Anaes.)	$910.40

GROUP O5 - PREPROSTHETIC

52600	Mandibular or palatal exostosis, excision of (Assist.) (Anaes.)	$611.40
52603	Mylohyoid ridge, reduction of (Assist.) (Anaes.)	$521.50
52606	Maxillary tuberosity, reduction of (Anaes.)	$397.80
52609	Papillary hyperplasia of the palate, removal of - less than 5 lesions (Assist.) (Anaes.)	$521.50

52612	Papillary hyperplasia of the palate, removal of - 5 to 20 lesions (Assist.) (Anaes.)	$654.70
52615	Papillary hyperplasia of the palate, removal of - more than 20 lesions (Assist.) (Anaes.)	$812.70
52618	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Assist.) (Anaes.)	$946.00
52621	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Assist.) (Anaes.)	$1,989.20
52624	Alveolar ridge augmentation with bone or alloplast or both - unilateral (Assist.) (Anaes.)	$856.80
52626	Alveolar ridge augmentation - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Assist.) (Anaes.)	$645.30
52627	Osseo-integration procedure - extra oral implantationof titanium fixture (Assist.) (Anaes.)	$986.30
52630	Osseo-integration procedure - fixation of transcutaneous abutment (Anaes.)	$441.70
52633	Osseo-integration procedure - intra- oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$1,624.70
52636	Osseo-integration procedure - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$783.50

GROUP O6 - NEUROSURGICAL

52800	Neurolysis by open operation, without transposition, not being a service associated with a service to which item 52803 applies (Assist.) (Anaes.)	$534.20
52803	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Assist.) (Anaes.)	$642.80
52806	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve (Assist.) (Anaes.)	$438.00
52809	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve (Assist.) (Anaes.)	$749.70
52812	Nerve trunk, primary repair of, using microsurgical techniques (Assist.) (Anaes.)	$1,091.70
52815	Nerve trunk, secondary repair of, using microsurgical techniques (Assist.) (Anaes.)	$2,935.60
52818	Nerve, transposition of (Assist.) (Anaes.)	$957.60
52821	Nerve graft to nerve trunk (cable graft) including harvesting of nerve graft using microsurgical techniques (Assist.) (Anaes.)	$1,630.50
52824	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Assist.) (Anaes.)	$715.40
52826	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	$376.00
52828	Cutaneous nerve, primary repair of, using microsurgical techniques (Assist.) (Anaes.)	$559.30
52830	Cutaneous nerve, secondary repair of, using microsurgical techniques (Assist.) (Anaes.)	$737.60
52832	Cutaneous nerve, nerve graft to, using microsurgical techniques (Assist.) (Anaes.)	$1,011.60

GROUP O7 - EAR, NOSE AND THROAT

53000	Maxillary antrum, proof puncture and lavage of (Anaes.)	$71.00
53003	Maxillary antrum, proof puncture and lavage of, under general anaesthesia, not being a service associated with a service to which another item in groups O3 to O9 applies ((Anaes.)	$168.20

53004	Maxillary antrum, lavage of - each attendance at which the procedure is performed, including any associated consultation (Anaes.)	$116.00
53006	Antrostomy (radical) (Assist.) (Anaes.)	$840.70
53009	Antrum, intranasal operation on or removal of foreign body from (Assist.) (Anaes.)	$521.20
53012	Antrum, drainage of, through tooth socket (Anaes.)	$202.50
53015	Oro-antral fistula, plastic closure of (Assist.) (Anaes.)	$947.80
53016	Nasal septum, septoplasty, submucous resection or closure of septal perforation (Assist.) (Anaes.)	$1,225.60
53017	Nasal septum, reconstruction of (Assist.) (Anaes.)	$2,336.00
53019	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Assist.) (Anaes.)	$1,351.10
53052	Post-nasal space, direct examination of, with or without biopsy (Anaes.)	$194.30
53054	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx - 1 or more of these procedures (Anaes.)	$483.20
53056	Examination of nasal cavity or post- nasal space, or nasal cavity and post-nasal space, under general anaesthesia, not being a service associated with a service to which another item in this group applies (Anaes.)	$115.90
53058	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (Anaes.)	$194.30
53060	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates for obstruction or haemorrhage secondary to surgery (or trauma) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)	$159.10
53062	Post-surgical nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$142.30
53064	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	$257.80
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.)	$128.80
53203	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	$187.90
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.)	$258.80
53209	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (Assist.) (Anaes.)	$2,609.70
53212	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Assist.) (Anaes.)	$1,808.80
53215	Temporomandibular joint, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Assist.) (Anaes.)	$1,737.60
53218	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions -1 or more of such procedures (Assist.) (Anaes.)	$1,747.60
53220	Temporomandibular joint, arthrotomy of, not being a service to which another item in this group applies (Assist.) (Anaes.)	$521.50

53221	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Assist.) (Anaes.)	$1,651.10
53224	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Assist.) (Anaes.)	$1,530.30
53225	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (Assist.) (Anaes.)	$537.00
53226	Temporomandibular joint, synovectomy of, not being a service to which another item in this group applies (Assist.) (Anaes.)	$494.40
53227	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Assist.) (Anaes.)	$1,880.40
53230	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Assist.) (Anaes.)	$4,520.80
53233	Temporomandibular joint, surgery of, involving procedures to which item 53224, 53226, 53227 or 53230 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Assist.) (Anaes.)	$4,789.20
53236	Temporomandibular joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this group applies (Assist.) (Anaes.)	$744.80
53239	Temporomandibular joint, arthrodesis of, not being a service to which another item in this group applies (Assist.) (Anaes.)	$744.80
53242	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Assist.) (Anaes.)	$537.90

GROUP O9 - TREATMENT OF FRACTURES

53400	Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting	$204.50
53403	Mandible, treatment of fracture of, not requiring splinting	$254.50
53406	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Assist.) (Anaes.)	$1,139.70
53409	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Assist.) (Anaes.)	$727.10
53410	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	$135.50
53411	Zygomatic bone, treatment of fracture of, requiring surgical reduction, by temporal, intra-oral or other approach (Anaes.)	$598.30
53412	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Assist.) (Anaes.)	$720.30
53413	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Assist.) (Anaes.)	$928.30
53414	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Assist.) (Anaes.)	$1,539.10
53415	Maxilla, treatment of fracture of, requiring open reduction (Assist.) (Anaes.)	$782.40
53416	Mandible, treatment of fracture of, requiring open reduction (Assist.) (Anaes.)	$702.70
53418	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Assist.) (Anaes.)	$896.40
53419	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Assist.) (Anaes.)	$1,032.00

53422	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Assist.) (Anaes.)	$1,797.50
53423	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Assist.) (Anaes.)	$1,197.90
53424	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Assist.) (Anaes.)	$2,024.70
53425	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Assist.) (Anaes.)	$1,293.60
53427	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (Assist.) (Anaes.)	$1,732.90
53429	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (Assist.) (Anaes.)	$1,646.00
53439	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	$425.10
53453	Orbital cavity, reconstruction of a wall or floor with or without foreign implant (Assist.) (Anaes.)	$1,162.20
53455	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Assist.) (Anaes.)	$1,767.20
53458	Nasal bones, treatment of fracture of, not being a service to which item 53459 or 53460 applies	$69.30
53459	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$532.60
53460	Nasal bones, treatment of fractures of, by open reduction involving osteotomies (Assist.) (Anaes.)	$1,682.50

GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

53600	Skin sensitivity testing for allergens to anaesthetics and materials used in oral and maxillofacial surgery, using1 to 20 allergens	$61.60

GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS

53700	Trigeminal nerve, primary division of, injection of ananaesthetic agent	$197.60
53702	Trigeminal nerve, peripheral branch of, injection of ananaesthetic agent	$99.00
53704	Facial nerve, injection of an anaesthetic agent	$59.50
53706	Nerve branch in the oral and maxillofacial region, destruction by a neurolytic agent, not being a service to which any other item in this group applies	$530.80

GROUP I1 - ULTRASOUND

General

55005	Head, ultrasound scan of, where:(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55007	Head, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60
55008	Orbital contents, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring medical	$88.20

	practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	
55010	Orbital contents, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60
55011	Neck, 1 or more structures of, ultrasound scan of, where:(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55013	Neck, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60
55014	Abdomen, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in subgroup 4,applies, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies;(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(c) the service is not performed with item 55017, 55020, 55038, 55044, 55731 or 55732 on the same patient within 24 hours (r) (nk)	$90.00
55016	Abdomen, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in subgroup 4,applies where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60
55017	Urinary tract, ultrasound scan of but not being a service associated with the service to which an item in subgroup 4,applies,,where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(c) the service is not performed with item 55041, 55020, 55036, 55044, 55731 or 55732 on the same patient within 24 hours (r) (nk)	$88.20
55019	Urinary tract, ultrasound scan of, but not being a service associated with the service to which an item in subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60
55020	Pelvis, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service to which an item in subgroup 4,applies, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (r) (nk)	$90.00
55022	Pelvis, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service to which an item in subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60
55023	Scrotum, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.50
55025	Scrotum, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	$30.60

55026	Ultrasonic cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies (r) (nk)	$88.20
55028	Head, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$200.20
55029	Head, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroup 2 or 3 applies (NR)	$70.80
55030	Orbital contents, ultrasound scan of, if:(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$249.30
55031	Orbital contents, ultrasound scan of, if the patient is no treferred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	$82.20
55032	Neck, 1 or more structures of, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$205.80
55033	Neck, 1 or more structures of, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	$72.00
55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a referringl practitioner for ultrasonic examination; and (b) the referring practitioner is not a member of a group of practitioners of which the practitioner is a member; and (c) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service described in item 55038, 55044 or 55731 is not performed on the same patient by the providing practitioner (R)	$207.90
55037	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is not referred by a medical practitioner;and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)	$68.60
55038	Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service described in item 55036, 55044 or 55731 is not performed on the same patient by the providing practitioner (R)	$207.90
55039	Urinary tract, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner;and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)	$72.00
55044	Pelvis, male, ultrasound scan of, by any or all approaches,if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the	$209.40

	prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service described in item 55036 or 55038 is not performed on the same patient by the providing practitioner (R)	
55045	Pelvis, male, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner;and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)	$72.00
55048	Scrotum, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$212.40
55049	Scrotum, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies(NR)	$75.10
55054	Ultrasonic cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies (R)	$205.20
55059	Breast, one, ultrasound scan of, where:(a) the patient is referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$79.50
55060	Breast, one, ultrasound scan of, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies (nr) (nk)	$27.60
55061	Breasts, both, ultrasound scan of, where:(a) the patient is referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55062	Breasts, both, ultrasound scan of, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies (nr) (nk)	$30.60
55063	Urinary bladder, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of the group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55600, 55601, 55603, 55604, 55014, 55017, 55020, 55036, 55038, 55044, 55731, 55732 or 11917 on the same date of service (r) (nk)	$79.50
55064	Urinary bladder, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 applies; and the service is not performed with item 55600, 55601, 55603, 55604, 55016, 55019, 55022, 55037, 55039, 55045, 55733, 55734 or 11917 on the same date of service (nr) (nk)	$27.60
55070	Breast, one, ultrasound scan of, if: (a) the patient is referred by a referring practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$201.50
55073	Breast, one, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR)	$62.00
55076	Breasts, both, ultrasound scan of, if: (a) the patient is referred by a referring practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3	$236.60

	applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	
55079	Breasts, both, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR)	$89.00
55084	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service described in item 11917, 55036, 55038, 55044, 55600, 55603 or55731 is not performed on the same patient by the providing practitioner (R)	$179.00
55085	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner;and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) within 24 hours of the service, a service described in item 11917, 55037, 55039, 55045, 55600, 55603 or55733 is not performed on the same patient by the providing practitioner (NR)	$62.00
	Cardiac	
55113	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R)	$427.90
55114	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic or embolic disease or heart tumour: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R)	$430.40
55115	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of congenital heart disease: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (r)	$424.90
55116	Exercise stress echocardiography performed in conjunction with item 11712: (a) with: (i) two-dimensional recordings before exercise (baseline) from at least 3 acoustic windows; and (ii) matching recordings from the same windows at, or immediately after, peak exercise; and (iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R)	$490.60
55117	Pharmacological stress echocardiography performed in conjunction with item 11712: (a) with: (i) two-dimensional recordings before drug infusion (baseline) from at least 3 acoustic windows; and (ii) matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose; and (iii) recordings on	$486.90

	digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R)	
55118	Heart, two-dimensional real time transoesophageal examination of, from at least 2 levels, and in more than1 plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3 applies (R)(Anaes.)	$507.40
55119	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (r) (nk)	$186.50
55120	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (r) (nk)	$186.50
55121	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of congenital heart disease (r) (nk)	$186.50
55122	Exercise stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup applies (with the exception of items 55118, 55125, 55130 and 55131). recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r) (nk)	$211.70
55123	Pharmacological stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup, applies (with the exception of items 55118, 55125, 55130 and 55131). recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r) (nk)	$211.70
55125	Heart, 2 dimensional real time transoesophageal examination of, from at least two levels, and in more than one plane at each level:(a) with: (i) real time colour flow mapping and, if indicated, pulsed wave doppler examination; and (ii) recordings on video tape or digital medium; and(b) not being an intra-operative service or a service associated with a service	$222.80

	to which an itemin subgroups 1 (with the exception of items 55026 and 55054) or 3, applies (r) (nk) (Anaes.)	
55130	Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure, not being a service associated with a service to which item 55135 applies (R)(Anaes.)	$313.60
55131	Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with items 55135 and 55136 (r) (nk) (Anaes.)	$137.50
55135	Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape ordigital 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.)	$652.40
55136	Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with items 55130 and 55131 (r) (nk) (Anaes.)	$285.90
	Vascular	
55220	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55221	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55222	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55223	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55224	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55226	Duplex scanning, bilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri- orbital doppler examination, not being a service associated	$137.10

	with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this groups applies (r) (nk)	
55227	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra- abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55228	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55229	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55230	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55232	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of:(a) priapism; or(b) fibrosis of any type; or(c) fracture of the tunica; or(d) arteriovenous malformations;where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this groups applies (r) (nk)	$137.10
55233	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk)	$137.10
55235	Duplex scanning, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or veins or arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this group applies - including any associated skin marking (r) (nk)	$137.10
55236	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this group applies - including any associated skin marking (r) (nk)	$89.80

55238	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated doppler flow measurements byspectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$320.90
55244	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$314.40
55246	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$322.80
55248	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$321.40
55252	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$318.40
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 Dopplerexamination, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$318.20
55276	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra- abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$314.70
55278	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$340.80
55280	Duplex scanning involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$306.40
55282	Duplex scanning involving B mode ultrasound imaging and integrated doppler flow measurements: (a) by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent; and (b) performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence; and (c) where a specialist in diagnostic radiology, nuclea rmedicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at thepractice location where the service is performed, immediately before or for a period during the performance of the service; and (d) where that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$317.70

55284	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements: (a) by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis; and (b) where indicated, assess the progress and management of: (i) priapism; or (ii) fibrosis of any type; or (iii) fracture of the tunica; or (iv) arteriovenous malformations; and (c) where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) where that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	$308.80
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 1 (with the exception of item 55054) or 4 applies (R)	$284.70
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 a service to which an item in Subgroup 1 (with the exception of item 55054), 3 or 4 applies (R)	$317.80
55296	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated doppler flow spectral analysis and marking of veins in the lower limbs below the inguinal ligament before varicose vein surgery, including any associated skin marking, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054), 3 or 4 applies (R)	$210.90

Urological

55600	Prostate, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a referring practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using a transducer probe that: (i) has a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days before the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) (K)	$203.90
55601	Prostate, bladder base and urethra, ultrasound scan of, where performed:(a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (r) (nk)	$88.20
55603	Prostate, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using a transducer probe that: (i) has a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant	$225.30

	physician in medical oncology who has: (i) examined the patient in the 60 days before the scan; and (ii) recommended the scan for the management ofthe patient's current prostatic disease (R) (K)	
55604	Prostate, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (r) (nk)	$88.20
	Obstetric and gynaecological	
55700	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, if:(a) the patient is referred by a medical practitioner or participating midwife; and(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and(f) 1 or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (r)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (r). fee is payable only for item 55700 or item 55707, not both items.	$121.10
55701	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (r)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 or 55714 (r) (nk). fee	$48.50

	is payable only for item 55700 or 55701, or, or item 55707 or 55714, not both items	
55702	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (nr)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 or 55716 (r) (nk). fee is payable only for item 55702 or 55703, or, item 55707 or 55714, not both items	$28.30
55703	Pelvis or abdomen, pregnancy-related or pregnancy complication, ultrasound scan of, by any or all approaches,where: (a) the patient is not referred by a medical practitioner;and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR)	$64.60
55704	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if:(a) the patient is referred by a medical practitioner or participating midwife; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (r)footnote: for nuchal translucency measurements performed when the pregnancy is dated	$133.00

	by a crown rump length of 45 to 84mm, refer to item number 55707 (r). fee is payable only for item 55704 or item 55707, not both items.	
55705	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner;and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR)	$64.60
55706	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, if:(a) the patient is referred by a medical practitioner or participating midwife; and(b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) if the patient is referred by a medical practitioner - the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and(f) the service is not performed in the same pregnancy as item 55709 (r)	$202.00
55707	pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if;(a) the patient is referred by a medical practitioner or participating midwife; and(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) if the patient is referred by a medical practitioner - the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) at least 1 condition mentioned in paragraph (f) of item 55704 is present; and(g) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (h) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (r)	$216.70
55708	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84 mm; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) at least 1 condition mentioned in paragraph (e) of item 55704 is present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (nr) (item is subject to subrule 11 (2))	$132.50
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, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3	$113.70

	applies; and (d) the service is not performed in the same pregnancy as item 55706 (nr) (item is subject to subrule 11 (2))	
55710	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (r)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55704 or 55707 (r) (nk). fee is payable only for item 55704 or 55710, or, item 55707 or 55714, not both items	$56.60
55711	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (nr)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55708 or 55716 (r) (nk). fee is payable only for item 55705 or 55711, or, item 55708 or 55716, not both items	$28.30
55712	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who: (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) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (r)	$212.20
55713	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all	$80.90

	approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner; and(b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) the service is not performed in the same pregnancy as item 55709 or 55717 (r) (nk)	
55714	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where;(a) the patient is referred by a medical practitioner; and(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and(f) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and(g) the service is not performed with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (r) (nk)	$56.60
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, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (nr)	$73.80
55716	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where;(a) the patient is not referred by a medical practitioner; and(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and(e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and(f) the service is not performed in conjunction with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (nr) (nk)	$28.30
55717	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the service is not performed in the same pregnancy as item 55706 or 55713 (nr) (nk)	$30.70
55718	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if:(a) the patient is referred by a medical practitioner or participating midwife; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) the service is not performed in the same pregnancy as item 55723; and (g) 1 or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete	$191.10

	mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (r)	
55719	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has a qualification recognised by the royal australian and new zealand college of obstetricians and gynaecologists as being equivalent to a diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (r) (nk)	$93.10
55720	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricians and gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (nr) (nk)	$32.30
55721	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner who: (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 roya laustralian 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 (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (r)	$212.20
55722	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member;and(e) the service is not performed in the same pregnancy as item 55723 or 55726; and(f) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal	$80.90

	anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (r) (nk)	
55723	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) the service is not performed in the same pregnancy as item 55718; and (e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetalcardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy;(xviii) premature labour;(xix) fetal infection;(xx) pregnancy after assisted reproduction;(xxi) trauma;(xxii) diabetes mellitus;(xxiii) hypertension;(xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) gross maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (nr)(item is subject to subrule 11 (2))	$70.10
55724	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where:(a) the patient is referred by a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has qualifications recognised by the royal australian and new zealand college of obstericians and gynaecologists as being equivalent to a diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (r) nk)	$93.10
55725	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricians and gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (nr)	$73.80
55726	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all	$30.70

	approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the service is not performed in the same pregnancy as item 55718 or 55722; and(e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (nr) (nk)	
55727	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricans and gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (nr) (nk)	$32.30
55729	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation, where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of fetaldeath, not being a service associated with a service to which an item in this group applies - examination and report (r)	$50.30
55730	Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this group applies (r) (nk)	$22.10
55731	Pelvis, female, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (r)	$201.10
55732	Pelvis, female, ultrasound scan of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(d) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (r) (nk)	$79.30
55733	Pelvis, female, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies (nr)	$64.60

55734	Pelvis, female, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies (nr) (nk)	$28.30
55735	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and(d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (r) (nk)	$102.70
55736	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (r)	$305.00
55737	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (nr) (nk)	$46.10
55739	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (nr)	$126.00
55759	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (e) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (f) the service described in item 55706, 55709, 55712, 55715 or 55762 is not performed in conjunction with the scan during the same pregnancy (r) (item is subject to subrule 11 (2))	$287.40
55760	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and(d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and(f) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 57721, 55762 or 55763 during the same pregnancy (r) (nk)	$121.30
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, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (e) the service described in item 55706, 55709, 55712, 55715 or 55759 is not performed in conjunction with the scan during the same pregnancy (nr)(item is subject to subrule 11 (2))	$162.10
55763	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all	$48.50

	approaches, with measurement of all parameters for dating purposes, where:(a) the patient is not referred by a medical practitioner; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and(d) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 55720, 55759 or 55760 during the same pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk)	
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 patient is referred 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) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (e) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (f) further examination is clinically indicated in the ame pregnancy in which item 55759 or 55762 has been performed; and (g) the service described in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the scan during the same pregnancy (r)	$295.20
55765	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner who is a member or fellow of the royal australian and new zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has a qualification recognised by the royal australian and new zealand college of obstericians and gynaecologists as equivalent to a diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and(d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and(f) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and(g) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 during the same pregnancy (r) (nk)	$129.40
55766	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, who is a member or fellow of the royal australian and new zealand college of obstetricians and gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (e) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 hasbeen performed; and (f) the service described in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the scan during the same pregnancy (nr)	$120.00
55767	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a member or fellow of the royal australian and new zealand college of obstetricians and gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759,	$52.60

	55760, 55762 or 55763 has been performed; and(f) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 or 55720 during the same pregnancy (nr) (nk)	
55768	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service described in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (r)(item is subject to subrule 11 (2))	$276.80
55769	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(b) the ultrasound confirms a multiple pregnancy; and(c) the patient is referred by a medical practitioner; and(d) the service is not performed in the same pregnancy as item 55770 or 55771; and (e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (r) (nk)	$121.30
55770	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner;and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (f) the service described in item 55718, 55721, 55723, or 55725 is not performed in conjunction with the scan during the same pregnancy (nr)(item is subject to subrule 11 (2))	$110.70
55771	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where:(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and(b) the patient is not referred by a medical practitioner; and(c) the service is not performed in the same pregnancy as item 55768 or 55759; and(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the service is not performed in conjunction with item 55718, 55721, 55723, 55724,,55725, 55726 or 55727 during the same pregnancy (nr) (nk)	$48.50
55772	Pelvis or abdomen, pregnancy-related or pregnancycomplication, fetal development and anatomy, ultrasoundscan of, by any or all approaches, if:(a) dating of the pregnancy as confirmed by ultrasoundis after 22 weeks of gestation; and(b) the patient is referred 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 hasbeen performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service described in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (r)	$295.20
55773	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) dating of the pregnancy as	$129.40

	confirmed by ultrasound is after 22 weeks of gestation; and(b) the patient is referred by a medical practitioner who is a member or fellow of the royal australian and new zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has a qualification recognised by the royal australian and new zealand college of obstericians and gynaecologists as equivalent to a diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and(c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 55771 has been performed; and(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (r) (nk)	
55774	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricians and gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 hasbeen performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (f) the service described in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (nr)	$120.00
55775	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal australian and new zealand college of obstetricians and gynaecologists, where:(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and(b) the patient is not referred by a medical practitioner; and(c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 5571 has been performed; and(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (nr) (nk)	$52.60
	Musculoskeletal	
55800	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$202.70
55801	Hand or wrist, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55802	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner(nr)	$72.00
55803	Hand or wrist, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55804	Forearm or elbow, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$208.80

55805	Forearm or elbow, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55806	Forearm or elbow, 1 or both sides, ultrasound scan of,where: (a) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner(nr)	$71.80
55807	Forearm or elbow, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55808	Shoulder or upper arm, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or-biceps subluxation; or- capsulitis and bursitis; or-evaluation of mass including ganglion; or-occult fracture; or-acromioclavicular joint pathology.(r)	$207.50
55809	Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. benefits are not payable when referred for non- specific shoulder pain alone.shoulder or upper arm, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or- biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or-acromioclavicular joint pathology (r) (nk)	$88.20
55810	Shoulder or upper arm, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and(b)the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or-biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or- acromioclavicular joint pathology.(nr)	$89.60
55811	Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. benefits are not payable when referred for non- specific shoulder pain alone.shoulder or upper arm, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or-biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or- acromioclavicular joint pathology (nr) (nk)	$30.60
55812	Chest or abdominal wall, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$207.50
55813	Chest or abdominal wall, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing	$88.20

	practitioner is a member (r) (nk)	
55814	Chest or abdominal wall, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$72.00
55815	Chest or abdominal wall, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55816	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$210.50
55817	Hip or groin, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55818	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies: and (b) the patient is not referred by a medical practitioner (nr)	$72.00
55819	Hip or groin, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies: and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55820	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$198.80
55821	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55822	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$63.30
55823	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55824	Buttock or thigh, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$210.50
55825	Buttock or thigh, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55826	Buttock or thigh, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$75.50
55827	Buttock or thigh, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55828	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific knee pain	$205.50

	alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfaces knee, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or-injury of collateral ligaments.(r)	
55829	Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfacesknee, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or- injury of collateral ligaments (r) (nk)	$88.20
55830	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfaces knee, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and(b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or- injury of collateral ligaments.(nr)	$72.00
55831	Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfacesknee, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or- injury of collateral ligaments (nr) (nk)	$30.60
55832	Lower leg, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$204.90
55833	Lower leg, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55834	Lower leg, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr)	$90.00
55835	Lower leg, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55836	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the	$204.00

	providing practitioner is a member (r)	
55837	Ankle or hind foot, 1 or both sides, ultrasound scan of, where:(a) the services is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55838	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr)	$72.00
55839	Ankle or hind foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55840	Mid foot or fore foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$214.20
55841	Mid foot or fore foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55842	Mid foot or fore foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$85.60
55843	Mid foot or fore foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55844	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$160.90
55845	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$70.70
55846	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$69.10
55847	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk)	$30.60
55848	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (r)	$248.80
55849	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 or 55026 (r) (nk)	$88.20

55850	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$315.20
55851	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where:(a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated;(b) the service is not performed in conjunction with items 55026, 55054, or 55800 to 55849, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$123.70
55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where: a) the patient is referred by a referring practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$182.60
55853	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where:a) the patient is referred by a medical practitionerb) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; andc) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk)	$88.20
55854	Paediatric spine, spinal cord and overlying subcutaneous tissues, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (nr)	$63.30
55855	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where: a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; andb) the patient is not referred by a medical practitioner (nr) (nk)	$30.60

GROUP I2 - COMPUTED TOMOGRAPHY

56001	Computed tomography - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (r) (k) (Anaes.)	$340.90
56007	Computed tomography - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (r) (k) (Anaes.)	$451.20
56010	Computed tomography - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (r) (k) (Anaes.)	$445.60
56013	Computed tomography - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.)	$457.20
56016	Computed tomography - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.)	$505.30
56022	Computed tomography - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.)	$414.80
56025	Cone beam computed tomography of teeth and supporting bone structures (r) (k) (Anaes.)	$183.00
56026	Cone beam computed tomography of teeth and supporting bone structures (r) (nk) (Anaes.)	$91.60
56028	Computed tomography - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to	$578.40

	intravenous contrast injection, when undertaken (R) (K) (Anaes.)	
56030	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.)	$406.10
56036	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.)	$581.60
56041	Computed tomography - scan of brain wihtout intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.)	$165.40
56047	Computed tomography - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.)	$227.00
56050	Computed tomography - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.)	$217.50
56053	Computed tomography - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.)	$214.70
56056	Computed tomography - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.)	$277.30
56062	Computed tomography - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.)	$189.50
56068	Computed tomography - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.)	$337.60
56070	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.)	$189.50
56076	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.)	$311.60
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) (K) (Anaes.)	$410.00
56107	Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service associated with a service to which item 56807 applies (R) (K) (Anaes.)	$594.90
56141	Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.)	$217.10
56147	Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (r) (nk) (Anaes.)	$287.40
56219	Computed tomography - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated	$610.50

	plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.)	
56220	Computed tomography - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$421.20
56221	Computed tomography - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$418.40
56223	Computed tomography - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$425.00
56224	Computed tomography - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$588.30
56225	Computed tomography - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$596.30
56226	Computed tomography - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$591.70
56227	Computed tomography - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$227.80
56228	Computed tomography - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$205.10
56229	Computed tomography - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$205.10
56230	Computed tomography - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cerival region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$297.10
56231	Computed tomography - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$297.10
56232	Computed tomography - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$297.10
56233	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$420.90
56234	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous	$630.40

	contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	
56235	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$225.80
56236	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$297.10
56237	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$437.80
56238	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$654.00
56239	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$205.00
56240	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$297.10
56259	Computed tomography - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.)	$275.90
56301	Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	$519.40
56307	Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	$680.90
56341	Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	$266.40
56347	Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	$379.00

56401	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.)	$364.50
56407	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) (Anaes.)	$617.00
56409	Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.)	$352.10
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) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.)	$622.30
56441	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.)	$174.80
56447	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest), with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.)	$303.90
56449	Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56441 applies (R) (NK) (Anaes.)	$187.40
56452	Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.)	$303.90
56501	Computed tomography - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.)	$526.80
56507	Computed tomography - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K) (Anaes.)	$826.20
56541	Computed tomography - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56841 or 57041 applies (R) (NK) (Anaes.)	$262.30
56547	Computed tomography - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56847 or 57047 applies (R) (NK) (Anaes.)	$414.10
56552	Computed tomography of colon for exclusion of colorectal neoplasia in symptomatic or high risk patients if:(a) the patient has had an incomplete colonoscopy in the 3 months before the scan; and(b) the date of incomplete colonoscopy is set out on the request for scan; and(c) the service is not a service to which items 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (r) (k) (Anaes.)	$1,074.60
56554	Computed tomography of colon for exclusion of colorectal neoplasia in symptomatic or high risk patients if:(a) the request for scan states that one of the following contraindications to colonoscopy is present:(i) suspected perforation of the colon;(ii) complete or high-grade obstruction that will not allow passage of the scope; and(b) the service must not be a service to which item 56301, 56307, 56401, 56407, 56409, 56412,	$1,055.10

	56501, 56507, 56801, 56807 or 57001 applies (r) (k) (Anaes.)	
56619	Computed tomography - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.)	$406.90
56625	Computed tomography - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.)	$562.90
56659	Computed tomography - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) (Anaes.)	$197.30
56665	Computed tomography - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.)	$280.30
56801	Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	$785.30
56807	Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	$950.60
56841	Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	$390.80
56847	Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	$532.90
57001	Computed tomography - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	$792.90
57007	Computed tomography- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	$952.60
57041	Computed tomography- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	$390.90
57047	Computed tomography- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	$475.40
57201	Computed tomography - pelvimetry (R) (K) (Anaes.)	$316.10
57247	Computed tomography - pelvimetry (R) (NK) (Anaes.)	$129.90
57341	Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table	$626.70

	applies (R) (K) (Anaes.)	
57345	Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.)	$404.70
57350	Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (k) (Anaes.)	$905.80
57351	Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (k) (Anaes.)	$919.70
57355	Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (nk) (Anaes.)	$443.30
57356	Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (nk) (Anaes.)	$442.30
57360	Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and:the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; orthe patient requires exclusion of coronary artery anomaly or fistula; orthe patient will be undergoing non-coronary cardiac surgery (r) (k) (Anaes.)	$1,132.20
57361	Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and:the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; orthe patient requires exclusion of coronary artery anomaly or fistula; orthe patient will be undergoing non-coronary cardiac surgery (r) (nk) (Anaes.)	$566.10

GROUP I3 - DIAGNOSTIC RADIOLOGY

Radiographic examination of extremities

57506	Hand, wrist, forearm, elbow or humerus (NR)	$63.90
57509	Hand, wrist, forearm, elbow or humerus (R)	$74.70
57512	Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (nr)	$81.80
57515	Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (R)	$101.20
57518	Foot, ankle, leg, knee or femur (NR)	$68.30
57521	Foot, ankle, leg, knee or femur (R)	$81.60
57524	Foot and ankle, or ankle and leg, or leg and knee, or knee or femur (NR)	$92.30
57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R)	$120.20
57529	Hand, wrist, forearm, elbow or humerus (nr) (nk)	$24.10
57530	Hand, wrist, forearm, elbow or humerus (r) (nk)	$32.20
57532	Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (nr) (nk)	$32.70
57533	Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (r) (nk)	$43.70
57535	Foot, ankle, leg, knee or femur (nr) (nk)	$26.30
57536	Foot, ankle, leg, knee or femur (r) (nk)	$35.20
57538	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (nr) (nk)	$40.00
57539	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (r) (nk)	$53.30

Radiographic examination of shoulder or pelvis

57700	Shoulder or scapula (NR)	$79.50
57702	Shoulder or scapula (nr) (nk)	$32.70
57703	Shoulder or scapula (R)	$100.60
57705	Shoulder or scapula (r) (nk)	$43.70
57706	Clavicle (NR)	$76.10
57708	Clavicle (nr) (nk)	$26.30
57709	Clavicle (R)	$83.10
57711	Clavicle (r) (nk)	$35.20
57712	Hip joint (R)	$91.10
57714	Hip joint (r) (nk)	$38.20
57715	Pelvic girdle (R)	$103.80
57717	Pelvic girdle (r) (nk)	$49.30
57721	Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R)	$186.10
57723	Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (r) (nk)	$80.30

Radiographic examination of head

57901	Skull, not in association with item 57902 (R)	$116.40

57902	Cephalometry, not in association with item 57901 (R)	$108.00
57903	Sinuses (R)	$86.20
57906	Mastoids (R)	$108.00
57909	Petrous temporal bones (R)	$108.00
57911	Skull, not in association with item 57902 or 57914 (r) (nk)	$52.20
57912	Facial bones orbit, maxilla or malar, any or all (R)	$87.30
57914	Cephalometry, not in association with item 57901 or 57911 (r) (nk)	$52.20
57915	Mandible, not by orthopantomography technique (R)	$88.20
57917	Sinuses (r) (nk)	$38.30
57918	Salivary calculus (R)	$91.90
57920	Mastoids (r) (nk)	$52.20
57921	Nose (R)	$88.20
57923	Petrous temporal bones (r) (nk)	$52.20
57924	Eye (R)	$80.00
57926	Facial bones orbit, maxilla or malar, any or all (r) (nk)	$38.20
57927	Temporomandibular joints (R)	$92.00
57929	Mandible, not by orthopantomography technique (r) (nk)	$38.20
57930	Teeth single area (R)	$68.60
57932	Salivary calculus (r) (nk)	$38.20
57933	Teeth full mouth (R)	$132.00
57935	Nose (r) (nk)	$38.20
57938	Eye (r) (nk)	$38.20
57939	Palatopharyngeal studies with fluoroscopic screening (R)	$108.40
57941	Temporomandibular joints (r) (nk)	$40.20
57942	Palatopharyngeal studies without fluoroscopic screening (R)	$91.10
57944	Teeth single area (r) (nk)	$26.60
57945	Larynx, lateral airways and soft tissues of the neck, not being a service associated with a service to which item 57939 or 57942 applies (R)	$79.80
57947	Teeth full mouth (r) (nk)	$63.30
57950	Palatopharyngeal studies with fluoroscopic screening (r) (nk)	$52.20
57953	Palatopharyngeal studies without fluoroscopic screening (r) (nk)	$40.20
57956	Larynx, lateral airways and soft tissues of the neck, not being a service associated with a service to which item 57939, 57942, 57950 or 57953 applies (r) (nk)	$35.20
57959	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (r) (nk)	$38.40
57960	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (r)	$80.60
57962	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (r) (nk)	$38.40

57963	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (r)	$80.50
57965	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (r) (nk)	$38.40
57966	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (r)	$80.00
57968	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (r) (nk)	$38.40
57969	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (r)	$84.00

Radiographic examination of spine

58100	Spine cervical (R)	$122.70
58102	Spine cervical (r) (nk)	$54.30
58103	Spine thoracic (R)	$102.20
58105	Spine thoracic (r) (nk)	$44.50
58106	Spine lumbosacral (R)	$138.20
58108	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r)	$184.10
58109	Spine sacrococcygeal (R)	$89.00
58111	Spine lumbosacral (r) (nk)	$62.30
58112	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (r)	$169.30
58114	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r) (nk)	$89.00
58115	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (r)	$184.10
58117	Spine sacrococcygeal (r) (nk)	$38.10
58120	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year	$184.10
58121	Note: an account issued or a patient assignment form must show the item numbers of the examinations performed under this itemspine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (r), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year	$184.10
58123	Spine, two examinations of the kind referred to in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (r) (nk)	$78.70
58124	Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (r) (nk)	$89.00
58126	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (r) (nk)	$89.00
58127	Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106 and 58109, 58111 and 58117 if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (r) (nk)	$89.00

Bone age study and skeletal surveys

58300	Bone age study (R)	$81.80
58302	Bone age study (r) (nk)	$32.40
58306	Skeletal survey (R)	$166.70
58308	Skeletal survey (r) (nk)	$72.30

Radiographic examination of thoracic region

58500	Chest (lung fields) by direct radiography (NR)	$52.60
58502	Chest (lung fields) by direct radiography (nr) (nk) chest (lung fields) by direct radiography (nr) (nk)	$28.60
58503	Chest (lung fields) by direct radiography (R)	$88.50
58505	Chest (lung fields) by direct radiography (r) (nk)	$38.20
58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R)	$134.30
58508	Chest (lung fields) by direct radiography with fluoroscopic screening (r) (nk)	$49.20
58509	Thoracic inlet or trachea (R)	$89.30
58511	Thoracic inlet or trachea (r) (nk)	$32.20
58521	Left ribs, right ribs or sternum (R)	$82.40
58523	Left ribs, right ribs or sternum (r) (nk)	$35.20
58524	Left and right ribs, left ribs and sternum, or right ribs and sternum (R)	$100.80
58526	Left and right ribs, left ribs and sternum, or right ribs and sternum (r) (nk)	$45.70
58527	Left ribs, right ribs and sternum (R)	$117.10
58529	Left ribs, right ribs and sternum (r) (nk)	$56.20

Radiographic examination of urinary tract

58700	Plain renal only (R)	$92.70
58702	Plain renal only (r) (nk)	$37.30
58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography - (r)	$284.00
58708	Intravenous pyelography, with or without preliminary plain films and with or without tomography - (r) (nk)	$127.70
58715	Antegrade or retrograde pyelography, with or without preliminary plain films and with preparation and contrast injection - 1 side - (r)	$230.10
58717	Antegrade or retrograde pyelography, with or without preliminary plain films and with preparation and contrast injection - 1 side - (r) (nk)	$122.60
58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$234.40
58720	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.)	$102.00
58721	Retrograde micturating cysto- urethrography, with preparation and contrast injection - (R) (Anaes.)	$213.80
58723	Retrograde micturating cystourethrography, with preparation and contrast injection - (r) (nk) (Anaes.)	$111.80

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, 58915 or 58924 applies (NR)	$49.40
58902	Plain abdominal only, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915, 58917, 58924 or 58926 applies (nr) (nk)	$28.80
58903	Plain abdominal only, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R)	$90.00
58905	Plain abdominal only, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915, 58917, 58924 or 58926 applies (r) (nk)	$38.50
58909	Barium or other opaque meal of 1 or more of pharynx, oesophagus, stomach or duodenum, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - (R)	$202.80
58911	Barium or other opaque meal of 1 or more of pharynx, oesophagus, stomach or duodenum, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942, 57945, 57950, 57953 or 57956 applies - (r) (nk)	$72.70
58912	Barium or other opaque meal of oesophagus, stomach, duodenum and follow through to colon, with or without screening of chest and with or without preliminary plain film (R)	$236.80
58914	Barium or other opaque meal of oesophagus, stomach, duodenum and follow through to colon, with or without screening of chest, with or without preliminary plain film (r) (nk)	$89.20
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.)	$245.80
58917	Barium or other opaque meal, small bowel series only, with or without preliminary plain film (r) (nk)	$63.90
58920	Small bowel enema, barium or other opaque study of the small bowel, including duodenal intubation, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (r) (nk) (Anaes.)	$112.00
58921	Opaque enema, with or without air contrast study and with or without preliminary plain films - (R)	$249.60
58923	Opaque enema, with or without air contrast study and with or without preliminary plain films - (r) (nk)	$109.50
58924	Graham's test (cholecystography), with preliminary plain films and with or without tomography - (R)	$160.80
58926	Graham's test (cholecystography), with preliminary plain films and with or without tomography - (r) (nk)	$68.00
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)	$143.10
58929	Cholegraphy direct, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (r) (nk)	$61.90
58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R)	$385.10

58935	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (r) (nk)	$166.20
58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R)	$312.90
58938	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (r) (nk)	$158.50
58939	Defaecogram (R)	$261.20
58941	Defaecogram (r) (nk)	$112.60

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)	$35.70
59104	Localisation of foreign body, if provided in conjunction with a service described in subgroups 1 to 12 of group i3 (r) (nk)	$17.30

Radiographic examination of breasts

59300	Mammography of both breasts, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (r)	$163.10
59301	Mammography of both breasts, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. unless otherwise indicated, mammography includes both breasts (r) (nk)	$72.30
59303	Mammography of one breast, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (r)	$101.40
59304	Mammography of one breast, if:(a) the patient is referred with a specific request for a unilateral mammogram; and(b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (r) (nk)	$43.70
59306	Mammary ductogram (galactography) - 1 breast (R)	$191.50
59307	Mammary ductogram (galactography) - 1 breast (r) (nk)	$81.10
59309	Mammary ductogram (galactography) - 2 breasts (R)	$335.90
59310	Mammary ductogram (galactography) - 2 breasts (r) (nk)	$162.20
59312	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques - (R)	$171.10
59313	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques - (r) (nk)	$70.40
59314	Radiographic examination of 1 breast, in conjunction with a surgical procedure using interventional techniques - (R)	$123.90
59315	Radiographic examination of 1 breast, in conjunction with a surgical procedure using interventional techniques - (r) (nk)	$42.50
59318	Radiographic examination of excised breast tissue to confirm satisfactory excision of 1 or	$92.50

	more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R)	
59319	Radiographic examination of excised breast tissue to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre- operative localisation in conjunction with a service under item 31536 - (r) (nk)	$38.10

Radiographic examination in connection with pregnancy

59503	Pelvimetry, not being a service associated with a service to which item 57201 applies (R)	$149.70
59504	Pelvimetry, not being a service associated with a service to which item 57201 or 57247 applies (r) (nk)	$72.30

Radiographic examination with opaque or contrast media

59700	Discography, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$196.20
59701	Discography, each disc, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.)	$78.20
59703	Dacryocystography, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R)	$162.90
59704	Dacryocystography, 1 side, with or without preliminary plain film and with preparation and contrast injection - (r) (nk)	$61.40
59712	Hysterosalpingography, with without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$219.90
59713	Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.)	$92.00
59715	Bronchography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$229.50
59716	Bronchography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.)	$116.10
59718	Phlebography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (r) (Anaes.)	$238.30
59719	Phlebography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.)	$108.90
59724	Myelography, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.)	$373.10
59725	Myelography, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 or 56259 applies - (r) (nk) (Anaes.)	$183.20
59733	Sialography, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R)	$198.30
59734	Sialography, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 or 57932 applies - (r) (nk)	$87.20
59736	Vasoepididymography, 1 side, - (R)	$178.00
59737	Vasoepididymography, 1 side, - (r) (nk)	$50.10
59739	Sinogram or fistulogram, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R)	$128.40
59740	Sinogram or fistulogram, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (r) (nk)	$59.70

59751	Arthrography, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R)	$230.20
59752	Arthrography, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (r) (nk)	$112.50
59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R)	$367.30
59755	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (r) (nk)	$177.50
59760	Peritoneogram (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R)	$228.00
59761	Peritoneogram (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (r) (nk)	$93.20
59763	Air insufflation during video - fluoroscopic imaging including associated consultation (R)	$228.70
59764	Air insufflation during video - fluoroscopic imaging including associated consultation (r) (nk)	$108.20

Angiography

59903	Angiocardiography including the service described in item 59970, 59974 or 61109, not being a service to which item 59912 or 59925 applies (r) (k) (Anaes.)	$231.10
59912	Selective coronary arteriography (r) (k), including the services described in item 59970, 59974 or 61109, not being a service to which item 59903 or 59925 applies (Anaes.)	$611.60
59925	Selective coronary arteriography and angiocardiography, including the services described in items 59903, 59912, 59970, 59974 or 61109 (r) (k) (Anaes.)	$736.60
59970	Angiography and/or digital subtraction angiography with fluoroscopy and image acquisition using a mobile image intensifier, one or more regions including any preliminary plain films, preparation and contrast injection (R) (K) (Anaes.)	$281.70
59971	Angiocardiography including the service described in item 59970, 59974 or 61109, not being a service to which item 59972 or 59973 applies (r) (nk) (Anaes.)	$96.00
59972	Selective coronary arteriography (r) (nk), including the service described in item 59970, 59974 or 61109, not being a service to which item 59971 or 59973 applies (Anaes.)	$308.40
59973	Selective coronary arteriography and angiocardiography, including the services described in items 59970, 59971, 59972, 59974 or 61109 (r) (nk) (Anaes.)	$351.50
59974	Angiography and/or digital subtraction angiography with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (r) (nk) (Anaes.)	$159.20
60000	Digital subtraction angiography, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (Anaes.)	$1,080.50
60003	Digital subtraction angiography, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (Anaes.)	$1,397.70
60006	Digital subtraction angiography, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (Anaes.)	$2,006.20
60009	Digital subtraction angiography, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (Anaes.)	$2,496.50
60012	Digital subtraction angiography, examination of thorax - 1 to 3 data acquisition runs (R) (Anaes.)	$1,056.90

60015	Digital subtraction angiography, examination of thorax - 4 to 6 data acquisition runs (R) (Anaes.)	$1,384.90
60018	Digital subtraction angiography, examination of thorax - 7 to 9 data acquisition runs (R) (Anaes.)	$2,056.40
60021	Digital subtraction angiography, examination of thorax - 10 or more data acquisition runs (R) (Anaes.)	$2,342.50
60024	Digital subtraction angiography, examination of abdomen - 1 to 3 data acquisition runs (R) (Anaes.)	$1,036.00
60027	Digital subtraction angiography, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.)	$1,499.50
60030	Digital subtraction angiography, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.)	$2,131.40
60033	Digital subtraction angiography, examination of abdomen - 10 or more data acquisition runs (R) (Anaes.)	$2,459.20
60036	Digital subtraction angiography, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.)	$1,002.20
60039	Digital subtraction angiography, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.)	$1,384.90
60042	Digital subtraction angiography, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.)	$2,071.40
60045	Digital subtraction angiography, examination of upper limb or limbs - 10 or more data acquisition runs (R) (Anaes.)	$2,430.00
60048	Digital subtraction angiography, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.)	$1,057.90
60051	Digital subtraction angiography, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.)	$1,438.70
60054	Digital subtraction angiography, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.)	$2,131.40
60057	Digital subtraction angiography, examination of lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.)	$2,501.20
60060	Digital subtraction angiography, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.)	$1,072.40
60063	Digital subtraction angiography, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.)	$1,531.10
60066	Digital subtraction angiography, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.)	$2,133.70
60069	Digital subtraction angiography, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.)	$2,521.40
60072	Selective arteriography or selective venography by digital subtraction angiography technique - 1 vessel (NR) (Anaes.)	$92.50
60075	Selective arteriography or selective venography by digital subtraction angiography technique - 2 vessels (NR) (Anaes.)	$180.30
60078	Selective arteriography or selective venography by digital subtraction angiography technique - 3 or more vessels (NR) (Anaes.)	$269.30

Tomography

60100	Tomography of any region (R) (Anaes.)	$114.20

60101	Tomography of any region (r) (nk) (Anaes.)	$49.20

Fluoroscopic examination

60500	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.)	$85.30
60501	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (r) (nk) (Anaes.)	$35.20
60503	Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination)(R)	$86.00
60504	Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination) (r) (nk)	$24.10
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 table applies (R)	$145.00
60507	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this table applies (r) (nk)	$51.70
60509	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (R)	$221.00
60510	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (r) (nk)	$80.00

Preparation for radiological procedure

60918	Arteriography (peripheral) or phlebography 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (nr) (Anaes.)	$79.00
60927	Selective arteriogram or phlebogram, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (nr) (Anaes.)	$71.20

Interventional techniques

61109	Fluoroscopy in an angiography suite with image intensification, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R)	$504.90
61110	Fluoroscopy in an angiography suite with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this table applies (r) (nk)	$209.40

GROUP I4 - NUCLEAR MEDICINE IMAGING

61302	Single stress or rest myocardial perfusion study - planar imaging(R)	$637.80
61303	Single stress or rest myocardial perfusion study - with single photon emission tomography and with planar imaging when undertaken (R)	$827.00
61306	Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R)	$1,016.90
61307	Combined stress and rest, stress and re-injection or rest and redistribution myocardial	$1,241.60

	perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R)	
61310	Myocardial infarct-avid-study, with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R)	$522.70
61313	Gated cardiac blood pool study, (equilibrium), with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R)	$433.00
61314	Gated cardiac blood pool study, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	$603.80
61316	Gated cardiac blood pool study, with intervention, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	$603.80
61317	Gated cardiac blood pool study, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R)	$708.90
61320	Cardiac first pass blood flow study or cardiac shunt study, not being a service to which another item in this Group applies (R)	$333.90
61328	Lung perfusion study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R)	$316.60
61340	Lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (R)	$306.90
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	$618.20
61352	Liver and spleen study (colloid) - planar imaging (R)	$376.50
61353	Liver and spleen study (colloid), with single photon emission tomography and with planar imaging when undertaken (R)	$572.00
61356	Red blood cell spleen or liver study, including single photon emission tomography when undertaken (R)	$556.70
61360	Hepatobiliary study, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R)	$727.50
61361	Hepatobiliary study with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R)	$805.00
61364	Bowel haemorrhage study (R)	$691.00
61368	Meckel's diverticulum study (R)	$326.50
61369	Indium-labelled octreotide study - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero- pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero- pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites.(R)	$3,375.30
61372	Salivary study (R)	$335.30
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when undertaken (R)	$668.10
61376	Oesophageal clearance study (R)	$215.80
61381	Gastric emptying study, using single tracer (R)	$987.70

61383	Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (R)	$936.40
61384	Radionuclide colonic transit study (R)	$1,151.50
61386	Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (R)	$454.90
61387	Renal cortical study, with single photon emission tomography and planar quantification (R)	$647.40
61389	Single renal study with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	$527.20
61390	Renal study with diuretic administration following a baseline study (R)	$561.30
61393	Combined examination involving a renal study following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R)	$882.40
61397	Cystoureterogram (R)	$375.30
61401	Testicular study (R)	$241.70
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when undertaken (R)	$892.00
61405	Brain study with blood brain barrier agent, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	$579.80
61409	Cerebro-spinal fluid transport study, with imaging on 2 or more separate occasions (R)	$1,156.80
61413	Cerebro-spinal fluid shunt patency study (R)	$333.90
61417	Dynamic blood flow study or regional blood volume quantitative study, not being a service associated with a service to which another item in this Group applies (R)	$181.70
61421	Bone study - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$690.60
61425	Bone study - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$869.30
61426	Whole body study using iodine (R)	$760.10
61429	Whole body study using gallium (R)	$806.20
61430	Whole body study using gallium, with single photon emission tomography (R)	$1,058.60
61433	Whole body study using cells labelled with technetium (R)	$681.60
61434	Whole body study using cells labelled with technetium, with single photon emission tomography (R)	$987.70
61437	Whole body study using thallium (R)	$812.70
61438	Whole body study using thallium, with single photon emission tomography (R)	$1,118.10
61441	Bone marrow study - whole body using technetium labelled bone marrow agents (R)	$674.80
61442	Whole body study, using gallium -- with single photon emission tomography of 2 or more body regions acquired separately (R)	$1,113.90
61445	Bone marrow study - localised using technetium labelled agent (R)	$382.50
61446	Localised bone or joint study, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R)	$468.50
61449	Localised bone or joint study and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R)	$774.50
61450	Localised study using gallium (R)	$577.60

61453	Localised study using gallium, with single photon emission tomography (R)	$859.10
61454	Localised study using cells labelled with technetium (R)	$482.80
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R)	$787.90
61458	Localised study using thallium (R)	$595.60
61461	Localised study using thallium, with single photon emission tomography (R)	$883.90
61462	Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484 or 61485 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R)	$216.00
61465	Venography (R)	$383.70
61469	Lymphoscintigraphy (R)	$582.60
61473	Thyroid study including uptake measurement when undertaken (R)	$316.30
61480	Parathyroid study, planar imaging and single photon emission tomography when undertaken (R)	$532.70
61484	Adrenal study (R)	$1,171.80
61485	Adrenal study, with single photon emission tomography (R)	$1,477.10
61495	Tear duct study (R)	$326.50
61499	Particle perfusion study (infra- arterial) or Le Veen shunt study (R)	$361.90
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61650 (r)	$167.50
61523	Whole body fdg pet study, performed for evaluation of a solitary pulmonary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration biopsy, or for which an attempt at pathological characterisation has failed.(r)	$1,595.80
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)	$1,595.80
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)	$1,508.80
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)	$1,595.80
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)	$1,672.80
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (r)	$1,537.20
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)	$1,595.80
61571	Whole body fdg pet study, for the further primary staging of patients with histologically proven carcinoma of the uterine cervix, at figo stage ib2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative	$1,595.80

	intent. (r)	
61575	Whole body fdg pet study, performed for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent. (r)	$1,541.40
61577	Whole body fdg pet study, performed for the staging of proven oesophageal or gej carcinoma, in patients considered suitable for active therapy (r).	$1,595.80
61598	Whole body fdg pet study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (r).	$1,595.80
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).	$1,595.80
61610	Whole body fdg pet study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (r).	$1,595.80
61616	Whole body fdg pet study for the initial staging of indolent non- hodgkin's lymphoma where clinical, pathological and imaging findings indicate that the stage is i or iia and the proposed management is definitive radiotherapy with curative intent. (r)	$1,595.80
61620	Whole body fdg pet study for the initial staging of newly diagnosed or previously untreated hodgkin's or non-hodgkin's lymphoma (excluding indolent non-hodgkin's lymphoma. (r)	$1,541.40
61622	Whole body fdg pet study to assess response to first line therapy either during treatment or within three months of completing definitive first line treatment for hodgkin's or non-hodgkin's lymphoma (excluding indolent non-hodgkin's lymphoma), payable once only. (r)	$1,595.80
61628	Whole body fdg pet study for restaging following confirmation of recurrence of hodgkin's or non- hodgkin's lymphoma (excluding indolent non-hodgkin's lymphoma). (r)	$1,595.80
61632	Whole body fdg pet study to assess response to second-line chemotherapy when stem cell transplantation is being considered, for hodgkin's or non-hodgkin's lymphoma (excluding indolent non-hodgkin's lymphoma). (r)	$1,541.40
61640	Whole body fdg pet study for initial staging of patients with biopsy- proven bone or soft tissue sarcoma (excluding gastrointestinal stromal tumour) considered by conventional staging to be potentially curable. (r)	$1,672.80
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)	$1,672.80
61650	Leukoscan study, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to ex-vivo wbc scanning.(r) note leukoscan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. the descriptor does not cover patients who are being investigated for other sites of infection	$1,488.10
61651	Single stress or rest myocardial perfusion study - planar imaging (r) (nk)	$363.10
61652	Single stress or rest myocardial perfusion study - with single photon emission tomography and with planar imaging when undertaken (r) (nk)	$457.20
61653	Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (r) (nk)	$573.90
61654	Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (r) (nk)	$675.20
61655	Myocardial infarct-avid-study, with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (r) (nk)	$297.10

61656	Gated cardiac blood pool study, (equilibrium), with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (r) (nk)	$245.40
61657	Gated cardiac blood pool study, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk)	$339.60
61658	Gated cardiac blood pool study, with intervention, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk)	$308.20
61659	Gated cardiac blood pool study, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (r) (nk)	$398.20
61660	Cardiac first pass blood flow study or cardiac shunt study, not being a service to which another item in this group applies (r) (nk)	$185.20
61661	Lung perfusion study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (r) (nk)	$184.10
61662	Lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (r) (nk)	$204.60
61663	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk)	$358.70
61664	Liver and spleen study (colloid) - planar imaging (r) (nk)	$209.80
61665	Liver and spleen study (colloid), with single photon emission tomography and with planar imaging when undertaken (r) (nk)	$312.70
61666	Red blood cell spleen or liver study, including single photon emission tomography when undertaken (r) (nk)	$317.60
61667	Hepatobiliary study, including morphine administration or pre- treatment with cholecystokinin (cck) when undertaken (r) (nk)	$326.20
61668	Hepatobiliary study with formal quantification following baseline imaging, using an infusion of cholecystokinin (cck) (r) (nk)	$373.20
61669	Bowel haemorrhage study (r) (nk)	$401.90
61670	Meckel's diverticulum study (r) (nk)	$180.40
61671	Indium-labelled octreotide study - including single photon emission tomography when undertaken, where:(a) there is a suspected gastro-entero- pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or(b) a surgically amenable gastro- entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (ministerial determination) (r) (nk)	$1,630.20
61672	Salivary study (r) (nk)	$180.40
61673	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when undertaken (r) (nk)	$396.00
61674	Oesophageal clearance study (r) (nk)	$116.00
61675	Gastric emptying study, using single tracer (r) (nk)	$464.50
61676	Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (r) (nk)	$505.50
61677	Radionuclide colonic transit study (r) (nk)	$556.20
61678	Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (r) (nk)	$268.90

61679	Renal cortical study, with single photon emission tomography and planar quantification (r) (nk)	$348.30
61680	Single renal study with pre- procedural administration of a diuretic or angiotensin converting enzyme (ace) inhibitor (r) (nk)	$299.70
61681	Renal study with diuretic administration following a baseline study (r) (nk)	$331.60
61682	Combined examination involving a renal study following angiotensin converting enzyme (ace) inhibitor provocation and a baseline study, in either order and related to a single referral episode (r) (nk)	$489.60
61683	Cystoureterogram (r) (nk)	$199.70
61684	Testicular study (r) (nk)	$131.30
61685	Cerebral perfusion study, with single photon emission tomography and with planar imaging when undertaken (r) (nk)	$489.30
61686	Brain study with blood brain barrier agent, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk)	$279.80
61687	Cerebro-spinal fluid transport study, with imaging on 2 or more separate occasions (r) (nk)	$706.40
61688	Cerebro-spinal fluid shunt patency study (r) (nk)	$182.80
61689	Dynamic blood flow study or regional blood volume quantitative study, not being a service associated with a service to which another item in this group applies (r) (nk)	$96.20
61690	Bone study - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (r) (nk)	$388.00
61691	Bone study - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (r) (nk)	$485.70
61692	Whole body study using iodine (r) (nk)	$448.70
61693	Whole body study using gallium (r) (nk)	$439.20
61694	Whole body study using gallium, with single photon emission tomography (r) (nk)	$533.30
61695	Whole body study using cells labelled with technetium (r) (nk)	$401.90
61696	Whole body study using cells labelled with technetium, with single photon emission tomography (r) (nk)	$497.70
61697	Whole body study using thallium (r) (nk)	$439.00
61698	Whole body study using thallium, with single photon emission tomography (r) (nk)	$544.30
61699	Bone marrow study - whole body using technetium labelled bone marrow agents (r) (nk)	$396.00
61700	Whole body study, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (r) (nk)	$608.50
61701	Bone marrow study - localised using technetium labelled agent (r) (nk)	$231.90
61702	Localised bone or joint study, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (r) (nk)	$269.80
61703	Localised bone or joint study and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (r) (nk)	$369.00
61704	Localised study using gallium (r) (nk)	$321.50
61705	Localised study using gallium, with single photon emission tomography (r) (nk)	$416.20
61706	Localised study using cells labelled with technetium (r) (nk)	$281.50
61707	Localised study using cells labelled with technetium, with single photon emission tomography (r) (nk)	$380.60
61708	Localised study using thallium (r) (nk)	$321.10

61709	Localised study using thallium, with single photon emission tomography (r) (nk)	$426.90
61710	Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484, 61485, 61669, 61692, 61693, 61694, 61700, 61704, 61705, 61712, 61715 or 61716 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (r) (nk)	$104.30
61711	Venography (r) (nk)	$214.70
61712	Lymphoscintigraphy (r) (nk)	$281.50
61713	Thyroid study including uptake measurement when undertaken (r) (nk)	$141.90
61714	Parathyroid study, planar imaging and single photon emission tomography when undertaken (r) (nk)	$312.90
61715	Adrenal study (r) (nk)	$712.40
61716	Adrenal study, with single photon emission tomography (r) (nk)	$808.10
61717	Tear duct study (r) (nk)	$180.40
61718	Particle perfusion study (intra- arterial) or le veen shunt study (r) (nk)	$204.60
61719	Ct scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic ct report is issued and only in association with items 61302 - 61729 (r) (nk)	$80.90
61729	Leukoscan study, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to ex-vivo wbc scanning. (ministerial determination) (nk) note leukoscan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. the descriptor does not cover patients who are being investigated for other sites of infection	$710.60

GROUP I5 - MAGNETIC RESONANCE IMAGING

Scan of head - for specified conditions

63001	Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for: - tumour of the brain or meninges (r) (Contrast) (Anaes.)	$614.10
63004	- inflammation of the brain or meninges (r) (Contrast) (Anaes.)	$614.10
63007	- skull base or orbital tumour (r) (Contrast) (Anaes.)	$614.10
63010	- Stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (r) (Contrast) (Anaes.)	$537.90
63013	Magnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for:- tumour of the brain or meninges (r) (nk) (contrast) (Anaes.)	$326.00
63014	- inflammation of the brain or meninges (r) (nk) (contrast) (Anaes.)	$326.00
63016	- skull base or orbital tumour (r) (nk) (contrast) (Anaes.)	$326.00
63017	- stereotactic scan of brain, with fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (r) (nk) (contrast) (Anaes.)	$271.70
63040	Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location	$537.90

	where the patient is referred by a specialist or by a consultant physician - scan of head for: - acoustic neuroma (r) (Contrast) (Anaes.)	
63043	- pituitary tumour (r) (Contrast) (Anaes.)	$563.20
63046	- toxic or metabolic or ischaemic encephalopathy (r) (contrast) (Anaes.)	$614.10
63049	- demyelinating disease of the brain (r) (Contrast) (Anaes.)	$614.10
63052	- congenital malformation of the brain or meninges (r) (Contrast) (Anaes.)	$614.10
63055	- venous sinus thrombosis (r) (Contrast) (Anaes.)	$614.10
63058	- head trauma (r) (Contrast) (Anaes.)	$614.10
63061	- epilepsy (r) (Contrast) (Anaes.)	$614.10
63064	- stroke (r) (Contrast) (Anaes.)	$614.10
63067	- carotid or vertebral artery desection (r) (Contrast) (Anaes.)	$614.10
63070	- intracranial aneurysm (r) (Contrast) (Anaes.)	$614.10
63073	- intracranial arteriovenous malformation (r) (Contrast) (Anaes.)	$614.10
63074	Note: benefits are payable for each service included by subgroup 2 on three occasions only in any 12 month periodmagnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for:- acoustic neuroma (r) (nk) (contrast) (Anaes.)	$271.70
63075	- pituitary tumour (r) (nk) (contrast) (Anaes.)	$289.80
63076	- toxic or metabolic or ischaemic encephalopathy (r) (nk) (contrast) (Anaes.)	$326.00
63077	- demyelinating disease of the brain (r) (nk) (contrast) (Anaes.)	$326.00
63078	- congenital malformation of the brain or meninges (r) (nk) (contrast) (Anaes.)	$326.00
63079	- venous sinus thrombosis (r) (nk) (contrast) (Anaes.)	$326.00
63080	- head trauma (r) (nk) (contrast) (Anaes.)	$326.00
63081	- epilepsy (r) (nk) (contrast) (Anaes.)	$326.00
63082	- stroke (r) (nk) (contrast) (Anaes.)	$326.00
63083	- carotid or vertebral artery desection (r) (nk) (contrast) (Anaes.)	$326.00
63084	- intracranial aneurysm (r) (nk) (contrast) (Anaes.)	$326.00
63085	- intracranial arteriovenous malformation (r) (nk) (contrast) (Anaes.)	$326.00
	Scan of head and neck vessels - for specified conditions	
63101	Magnetic resonance imaging and magnetic resonance angiography of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and neck vessels for:- stroke (r) (Contrast) (Anaes.)	$733.10
63104	Note: benefits are payable for each service included by subgroup 3 on three occasions only in any 12 month periodmagnetic resonance imaging and magnetic resonance angiography of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and neck vessels for:- stroke (r) (nk) (contrast) (Anaes.)	$398.60
63117	Magnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for:- tumour of the central nervous system or meninges (r) (nk) (contrast) (Anaes.)	$398.60

63119	- inflammation of the central nervous system or meninges (r) (nk) (contrast) (Anaes.)	$398.60

Scan of head and cervical spine - for specified conditions

63111	Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for: - tumour of the central nervous system or meninges (r) (Contrast) (Anaes.)	$733.10
63114	- Inflammation of the central nervous system or meninges (r) (Contrast) (Anaes.)	$733.10
63125	Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for:- demyelinating disease of the central nervous system (r) (Contrast) (Anaes.)	$733.10
63128	- congenital malformation of the central nervous system or meninges (r) (Contrast) (Anaes.)	$733.10
63131	- syrinx (congenital or aquired) (r) (Contrast) (Anaes.)	$733.10
63134	Note: benefits are payable for each service included by subgroup 5 on three occasions only in any 12 month periodmagnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for:- demyelinating disease of the central nervous system (r) (nk) (contrast) (Anaes.)	$398.60
63135	- congenital malformation of the central nervous system or meninges (r) (nk) (contrast) (Anaes.)	$398.60
63136	- syrinx (congenital or aquired) (r) (nk) (contrast) (Anaes.)	$398.60

Scan of spine - one region or two contiguous regions - for specified conditions

63151	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - infection (r) (Contrast) (Anaes.)	$563.20
63154	- tumour (r) (Contrast) (Anaes.)	$563.20
63157	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for:- infection (r) (nk) (contrast) (Anaes.)	$289.80
63158	- tumour (r) (nk) (contrast) (Anaes.)	$289.80
63161	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - demyelinating (r) (Contrast) (Anaes.)	$563.20
63164	- congenital malformation of the spinal cord or the cauda equina or the meninges (r) (Contrast) (Anaes.)	$563.20
63167	- myelopathy (r) (Contrast) (Anaes.)	$563.20
63170	- syrinx (congenital or aquired) (r) (Contrast) (Anaes.)	$563.20
63173	- cervical radiculopathy (r) (Contrast) (Anaes.)	$563.20
63176	- sciatica (r) (Contrast) (Anaes.)	$563.20
63179	- spinal canal stenosis (r) (Contrast) (Anaes.)	$563.20

63182	- previous spinal surgery (r) (Contrast) (Anaes.)	$563.20
63185	- trauma (r) (Anaes.)	$563.20
63186	Note: benefits are payable for each service included by subgroup 7 on three occasions only in any 12 month periodmagnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for:- demyelinating (r) (nk) (contrast) (Anaes.)	$289.80
63187	- congenital malformation of the spinal cord or the cauda equina or the meninges (r) (nk) (contrast) (Anaes.)	$289.80
63188	- myelopathy (r) (nk) (contrast) (Anaes.)	$289.80
63189	- syrinx (congenital or aquired) (r) (nk) (contrast) (Anaes.)	$289.80
63190	- cervical radiculopathy (r) (nk) (contrast) (Anaes.)	$289.80
63191	- sciatica (r) (nk) (contrast) (Anaes.)	$289.80
63192	- spinal canal stenosis (r) (nk) (contrast) (Anaes.)	$289.80
63193	- previous spinal surgery (r) (nk) (contrast) (Anaes.)	$289.80
63194	- trauma (r) (nk) (Anaes.)	$289.80

Scan of spine - three contiguous regions or two non-contiguous regions - for specified conditions

63201	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- infection (r) (Contrast) (Anaes.)	$673.70
63204	- tumour (r) (Contrast) (Anaes.)	$673.70
63207	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- infection (r) (nk) (contrast) (Anaes.)	$362.20
63208	- tumour (r) (nk) (contrast) (Anaes.)	$362.20
63219	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- demyelinating disease (r) (Contrast) (Anaes.)	$673.70
63222	- congenital malformation of the spinal cord or the cauda equina or the meninges (r) (Contrast) (Anaes.)	$673.70
63225	- myelopathy (r) (Contrast) (Anaes.)	$673.70
63228	- syrinx (congenital or aquired) (r) (Contrast) (Anaes.)	$673.70
63231	- cervical radiculopathy (r) (Contrast) (Anaes.)	$673.70
63234	- sciatica (r) (Contrast) (Anaes.)	$673.70
63237	- spinal canal stenosis (r) (Contrast) (Anaes.)	$673.70
63240	- previous spinal surgery (r) (Contrast) (Anaes.)	$673.70
63243	- trauma (r) (Anaes.)	$673.70
63257	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- demyelinating disease (r) (nk) (contrast) (Anaes.)	$362.20

63258	- congenital malformation of the spinal cord or the cauda equina or the meninges (r) (nk) (contrast) (Anaes.)	$362.20
63259	- myelopathy (r) (nk) (contrast) (Anaes.)	$362.20
63260	- syrinx (congenital or aquired) (r) (nk) (contrast) (Anaes.)	$362.20
63261	- cervical radiculopathy (r) (nk) (contrast) (Anaes.)	$362.20
63262	- sciatica (r) (nk) (contrast) (Anaes.)	$362.20
63263	- spinal canal stenosis (r) (nk) (contrast) (Anaes.)	$362.20
63264	- previous spinal surgery (r) (nk) (contrast) (Anaes.)	$362.20
63265	- trauma (r) (nk) (Anaes.)	$362.20

Scan of cervical spine and brachial plexus - for specified conditions

63271	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cervcial spine and brachial plexus for: - tumour (r) (Contrast) (Anaes.)	$733.10
63274	- trauma (r) (Contrast) (Anaes.)	$733.10
63277	- cervical radiculopathy (r) (Contrast) (Anaes.)	$733.10
63280	- previous surgery (r) (Contrast) (Anaes.)	$733.10
63282	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cervical spine and brachial plexus for:- tumour (r) (nk) (contrast) (Anaes.)	$398.60
63283	- trauma (r) (nk) (contrast) (Anaes.)	$398.60
63284	- cervical radiculopathy (r) (nk) (contrast) (Anaes.)	$398.60
63285	- previous surgery (r) (nk) (contrast) (Anaes.)	$398.60

Scan of musculoskeletal system - for specified conditions

63301	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (r) (Contrast) (Anaes.)	$588.40
63304	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (r) (Contrast) (Anaes.)	$588.40
63307	- osteonecrosis (r) (Contrast) (Anaes.)	$588.40
63310	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (r) (nk) (contrast) (Anaes.)	$307.90
63311	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (r) (nk) (contrast) (Anaes.)	$307.90
63313	- osteonecrosis (r) (nk) (contrast) (Anaes.)	$307.90
63322	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - derangement of hip or its supporting structures (r) (Contrast) (Anaes.)	$614.30

63325	- derangment of shoulder or its supporting structures (r) (Contrast) (Anaes.)	$614.30
63328	- derangment of knee or its supporting structures (r) (Contrast) (Anaes.)	$614.30
63331	- derangment of ankle and/or foot or its supporting structures (r) (Contrast) (Anaes.)	$614.30
63334	- derangment of one or both temporomandibular joints or their supporting structures (r) (Contrast) (Anaes.)	$537.90
63337	- derangment of wrist and/or hand or its supporting structures (r) (Contrast) (Anaes.)	$673.70
63340	- derangment of elbow or its supporting structures (r) (Contrast) (Anaes.)	$614.30
63341	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- derangement of hip or its supporting structures (r) (nk) (contrast) (Anaes.)	$326.00
63342	- derangement of shoulder or its supporting structures (r) (nk) (contrast) (Anaes.)	$326.00
63343	- derangement of knee or its supporting structures (r) (nk) (contrast) (Anaes.)	$326.00
63345	- derangement of ankle and/or foot or its supporting structures (r) (nk) (contrast) (Anaes.)	$326.00
63346	- derangement of one or both temporomandibular joints or their supporting structures (r) (nk) (contrast) (Anaes.)	$271.70
63347	- derangement of wrist and/or hand or its supporting structures (r) (nk) (contrast) (Anaes.)	$362.20
63348	- derangement of elbow or its supporting structures (r) (nk) (contrast) (Anaes.)	$326.00
63361	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - Gaucher disease (r) (Anaes.)	$614.30
63364	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- gaucher disease (r) (nk) (Anaes.)	$326.00
	Scan of cardiovascular system - for specified conditions	
63385	Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for: - congenital disease of the heart or a great vessel (r) (Contrast) (Anaes.)	$673.70
63388	- tumour of the heart or a great vessel (r) (Contrast) (Anaes.)	$673.70
63391	- abnormality of thoracic aorta (r) (Contrast) (Anaes.)	$614.30
63392	Note: benefits are payable for each service included by subgroup 14 on two occasions only in any 12 month periodmagnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for:- congenital disease of the heart or a great vessel (r) (nk) (contrast) (Anaes.)	$362.20
63393	- tumour of the heart or a great vessel (r) (nk) (contrast) (Anaes.)	$362.20
63394	- abnormality of thoracic aorta (r) (nk) (contrast) (Anaes.)	$326.00
	Magnetic resonance angiography - scan of cardiovascular system - for specified conditions	
63401	Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for: - vascular abnormality in a	$614.30

	patient with a previous anaphylactic reaction to an iodinated contrast medium (r) (Contrast) (Anaes.)	
63404	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (r) (Contrast) (Anaes.)	$614.30
63407	Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for:- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (r) (nk) (contrast) (Anaes.)	$326.00
63408	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (r) (nk) (contrast) (Anaes.)	$326.00

Magnetic resonance angiography - for specified conditions - person under the age of 16 years

63416	Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (r) (Contrast) (Anaes.)	$614.30
63419	Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (r) nk) (contrast) (Anaes.)	$326.00
63425	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - post- inflammatory or post-traumatic physeal fusion (r) (Anaes.)	$614.30
63428	- Gaucher disease (r) (Anaes.)	$614.30
63432	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- post- inflammatory or post-traumatic physeal fusion (r) (nk) (Anaes.)	$326.00
63433	- gaucher disease (r) (nk) (Anaes.)	$326.00
63440	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - pelvic or abdominal mass (r) (Contrast) (Anaes.)	$614.30
63443	- mediastinal mass (r) (Contrast) (Anaes.)	$614.30
63446	- congenital uterine or anorectal abnormality (r) (Contrast) (Anaes.)	$614.30
63447	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- pelvic or abdominal mass (r) (nk) (contrast) (Anaes.)	$326.00
63448	- mediastinal mass (r) (nk) (contrast) (Anaes.)	$326.00
63449	- congenital uterine or anorectal abnormality (r) (nk) (contrast) (Anaes.)	$326.00

Scan of body - for specified conditions

63455	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a	$289.80

	consultant physician - scan of body for:- adrenal mass in a patient with malignancy which is otherwise resectable (r) (nk) (Anaes.)	
63457	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and(b) the request for scan identifies that the woman is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (a) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (b) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives: - has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has ashkenazi jewish ancestry; - is a male relative who has been diagnosed with breast cancer; (c) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. scan of both breasts for:- detection of cancer (r) note: benefits are payable on one occasion only in any 12 month period(nk) (Anaes.)	$557.90
63458	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:(a) a dedicated breast coil is used; and (b) the woman has had an abnormality detected as a result of a service described in item 63464 or 63457 performed in the previous 12 monthsscan of both breasts for: - detection of cancer (r) note 1: benefits are payable on one occasion only in any 12 month periodnote 2: this item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 or 63457(nk) (Anaes.)	$557.90
63461	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of body for: - adrenal mass in a patient with malignancy which is otherwise resecetable (r) (Anaes.)	$563.20
63464	Note: benefits are payable on one occasion only in any 12 month period Magnetic Resonance Imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the woman is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (a) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (b) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives: - has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has ashkenazi jewish ancestry; - is a male relative who has been diagnosed with breast cancer; (c) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. scan of both breasts for: - detection of cancer (R) (Anaes.)	$1,174.30
63466	Note: benefits are payable on one occasion only in any 12 month period magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the woman is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer due to 1 of	$1,155.50

	the following:(a) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer;(b) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives: - has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has ashkenazi jewish ancestry; - is a male relative who has been diagnosed with breast cancer;(c) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. scan of both breasts for:- detection of cancer note: benefits are payable on one occasion only in any 12 month period(r) (Anaes.)	
63467	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:(a) a dedicated breast coil is used; and (b) the woman has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 monthsscan of both breasts for: - detection of cancer (r)note 1: benefits are payable on one occasion only in any 12 month periodnote 2: this item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 (Anaes.)	$1,169.60
63469	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:(a) a dedicated breast coil is used; and (b) the woman has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 monthsscan of both breasts for: - detection of cancer (r)note 1: benefits are payable on one occasion only in any 12 month periodnote 2: this item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63466 (Anaes.)	$1,155.50
	Scan of pelvis and upper abdomen - for specified conditions	
63470	Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where: (a) the patient is referred by a specialist or by a consultant physician and (b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at figo stage 1b or greater Scan of: - Pelvis for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (Contrast) (Anaes.)	$614.30
63473	- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (Contrast) (Anaes.)	$911.30
63476	Note: benefits are payable for a service under item 63476 on one occasion only.magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and(b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum).scan of:- pelvis for the initial staging of rectal cancer (r) (contrast) (Anaes.)	$675.00
63478	Note: benefits are payable for a service included by subgroup 20 on one occasion only.magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and(b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum).scan of:- pelvis for the initial staging of rectal cancer (r) (contrast) (Anaes.)	$675.00
63479	Note: benefits are payable for a service included by subgroup 20 on one occasion only.magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where:(a) the patient is referred by a specialist or by a consultant physician and(b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed	$326.00

	with cervical cancer at figo stage 1b or greaterscan of:- pelvis for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (nk) (contrast) (Anaes.)	
63481	- pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (nk) (contrast) (Anaes.)	$507.20
	Scan of body - for specified conditions	
63482	Note: benefits are only payable for each service included by subgroup 21 on three occasions only in any 12 month periodmagnetic resonance imaging performed under the professional supervision of an eligible provider at an eligiblelocation where the patient is referred by a specialist or by a consultant physician - scan of pancreas and biliary tree for:- suspected biliary or pancreatic pathology (r) (anaes.)	$675.00
63484	Note: benefits are payable for a service included by subgroup 20 on one occasion only.magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and(b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum).scan of:- pelvis for the initial staging of rectal cancer (r) (nk) (contrast) (anaes.)	$326.00
63486	Note: benefits are only payable for each service included by subgroup 21 on three occasions only in any 12 month periodmagnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of pancreas and biliary tree for:- suspected biliary or pancreatic pathology (r) (nk) (anaes.)	$326.00
	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.modifying items for use with magnetic resonance imaging or magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the service requested by a medical practitioner. scan performed:- involves the use of contrast agent for eligible magnetic resonance imaging items (note: (contrast) denotes an item eligible for use with this item)	$75.10
63494	- involves use of intravenous or intramuscular sedation on a patient	$75.10
63497	- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic	$262.50
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	$72.40
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.	$253.60
	Magnetic Resonance Imaging – PIP breast implant	
63501	MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient:(i) has or is suspected of having a silicone breast implant manufactured by poly implant prosthese (pip); and (ii) the result of the scan confirms a loss of integrity of the implant (R) note: benefits are payable on one occasion only in any 12 month period	$808.70
63502	MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient:(i) has or is suspected of having a silicone breast implant manufactured by poly implant	$808.70

	prosthese (PIP); and (ii) the result of the scan does not demonstrate a loss of integrity of the implant (R) note: benefits are payable on one occasion only in any 12 month period	
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)	$808.70
63505	MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by poly implant 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)	$808.70
	Magnetic Resonance Imaging – for specified conditions – person under the age of 16 years	
63507	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for any of the following: unexplained seizure(s) (r) (contrast) (anaes.); orunexplained headache where significant pathology is suspected (r) (contrast) (anaes.); orparanasal sinus pathology which has not responded to conservative therapy (r) (contrast) (anaes.)	$614.10
63508	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for any of the following: unexplained seizure(s) (r) (nk) (contrast) (anaes.); orunexplained headache where significant pathology is suspected (r) (nk) (contrast) (anaes.); orparanasal sinus pathology which has not responded to conservative therapy (r) (nk) (contrast) (anaes.)	$326.00
63510	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine following radiographic examination for any of the following:significant trauma (r) (contrast) (anaes.); orunexplained neck or back pain with associated neurological signs (r) (contrast) (anaes.); orunexplained back pain where significant pathology is suspected (r) (contrast) (anaes.)	$673.70
63511	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine following radiographic examination for any of the following:significant trauma (r) (nk) (contrast) (anaes.); orunexplained neck or back pain with associated neurological signs (r) (nk) (contrast) (anaes.); orunexplained back pain where significant pathology is suspected (r) (nk) (contrast) (anaes.)	$362.20
63513	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee following radiographic examination for internal joint derangement. (r) (contrast) (anaes.)	$614.30
63514	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee following radiographic examination for internal joint derangement. (r) (nk) (contrast) (anaes.)	$326.00
63516	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip following radiographic examination for any of the following: suspected septic arthritis (r) (contrast) (anaes.); orsuspected slipped capital femoral epiphysis (r) (contrast) (anaes.); or suspected perthes disease (r) (contrast) (anaes.)	$614.30
63517	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip following radiographic examination for any of the following: suspected septic arthritis (r) (nk) (contrast) (anaes.); orsuspected slipped capital femoral epiphysis (r) (nk) (contrast) (anaes.); orsuspected perthes disease (r) (nk) (contrast) (anaes.)	$326.00
63519	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow following radiographic examination where a significant fracture or avulsion injury is suspected that would change the way in which the patient is managed. (r) (contrast) (anaes.))	$614.30

63520	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow following radiographic examination where a significant fracture or avulsion injury is suspected that would change the way in which the patient is managed. (r) (nk) (contrast) (anaes.)	$326.00
63522	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist following radiographic examination where scaphoid fracture is suspected (r) (contrast) (anaes.)	$673.70
63523	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist following radiographic examination where scaphoid fracture is suspected (r) (nk) (contrast) (anaes.)	$362.20

GROUP P1 - HAEMATOLOGY

65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity 1 or more tests	$13.80
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alphanaphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072	$12.70
65070	Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072	$28.50
65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests	$17.10
65075	Haemolysis or metabolic enzymes - assessment by: (a) erythrocyte autohaemolysis test; or (b) erythrocyte osmotic fragility test; or (c) sugar water test; or (d) G-6-P D (qualitative or quantitative) test; or (e) pyruvate kinase (qualitative or quantitative) test; or (f) acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests - 1 or more tests	$78.50
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	$151.90
65079	Tests described in item 65078 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$151.90
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	$163.00
65082	Tests described in item 65081 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$163.00
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	$281.30
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070	$140.00
65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen)	$18.70
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)	$37.10

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	$69.20
65099	Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (item is subject to rule 5)	$186.40
65102	Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject rule 5)	$277.90
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)	$188.30
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)	$241.70
65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy 1 release.	$22.80
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.	$22.80
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected)	$40.30
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies	$11.20
65117	1 or more of the following tests: (a) spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test)	$34.10
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	$23.20
65123	2 tests described in item 65120	$35.10
65126	3 tests described in item 65120	$51.20
65129	4 or more tests described in item 65120	$60.80
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	$42.70
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	$42.70
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	$95.40
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test	$63.50

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)	$119.60
65153	2 tests described in item 65150 (Item is subject to rule 6)	$239.10
65156	3 or more tests described in item 65150 (Item is subject to rule 6)	$358.70
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)	$119.60
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)	$119.60
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test	$119.60
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test)	$19.80
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)	$58.10
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	$42.70
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)	$42.70
65176	2 tests described in item 65175 (Item is subject to rule 6)	$82.00
65177	3 tests described in item 65175 (Item is subject to rule 6)	$121.30
65178	4 tests described in item 65175 (Item is subject to rule 6)	$160.50
65179	5 tests described in item 65175 (Item is subject to rule 6)	$199.80
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)	$42.70
65181	Tests described in item 65175, other than that described in 65180, if rendered by a receiving APA - each test to a maximum of 4 tests (Item is subject to rule 6 and 18)	$39.30

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	$11.80
66503	2 tests described in item 66500	$14.20
66506	3 tests described in item 66500	$16.60
66509	4 tests described in item 66500	$19.10
66512	5 or more tests described in item 66500	$21.70

66517	Quantitation of bile acids in blood in pregnancy. to a maximum of 3 tests in a pregnancy.	$33.10
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	$33.30
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	$73.00
66536	Quantitation of hdl cholesterol	$13.50
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/l and triglyceride >4.0 mmol/l or in the diagnosis of types iii and iv hyperlipidaemia - (Item is subject to rule 25)	$38.90
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; (b) at least 2 measurements of blood glucose; and if performed (c) any test described in item 66695	$28.00
66545	Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes:(a) administration of glucose; and (b) 1 or 2 measurements of blood glucose; and (c) (if performed) any test in item 66695	$28.40
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)	$35.20
66551	Quantitation of glycosylated haemoglobin performed in the management of established diabetes - (Item is subject to rule 25)	$28.20
66554	Quantitation of glycosylated 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)	$28.20
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period	$16.30
66560	Microalbumin - quantitation in urine	$34.00
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests	$30.20
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	$47.70
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day	$71.80
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day	$86.10
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day	$101.70
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day	$116.00
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day	$130.40
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test	$16.30
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen	$80.00
66590	Calculus, analysis of 1 or more	$58.60

66593	Ferritin - quantitation, except if requested as part of iron studies	$30.30
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b)transferrin or iron binding capacity; and (c) ferritin	$54.80
66599	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 21)	$39.70
66602	Serum B12 and red cell folate and, if required, serum folate, (Item is subject to rule 21)	$72.30
66605	Vitamins - quantitation of vitamins b1, b2, b3, b6 or c in blood, urine or other body fluid - 1 or more tests	$51.70
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)	$51.70
66607	Vitamins - quantitation of vitamins a or e in blood, urine or other body fluid - 1 or more tests within a 6 month period	$127.70
66608	Vitamin D or D fractions - 1 or more tests	$71.30
66609	A test described in item 66608 if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$71.30
66610	A test described in item 66607 if rendered by a receiving app - 1 or more tests	$123.40
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	$50.60
66626	Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient participating in a drug abuse treatment program; but excluding the surveillance of sports people and athletes for performance improving substances; including all tests on blood, urine or other body fluid (Item is subject to rule 25)	$40.60
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests	$34.00
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests	$34.00
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests	$34.00
66638	Isoelectric focussing or similar methods for determination of alpha-1- antitrypsin phenotype in serum - 1 or more tests	$59.80
66639	A test described in item 66638 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$49.30
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	$49.30
66642	A test described in item 66641 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$49.30
66644	C-1 esterase inhibitor - quantitation	$24.60
66647	C-1 esterase inhibitor - functional assay	$55.00
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)	$41.00

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)	$41.00
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)	$34.30
66653	2 or more tests described in item 66650 (Item is subject to rule 6)	$75.20
66655	Prostate specific antigen - quantitation - 1 of this item in a 12 month period (Item is subject to rule 25)	$34.00
66656	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)	$34.00
66659	Prostate specific antigen - quantitation of 2 or more fractions of psa and any derived index including (if performed) a test described in item 66656, in the followup of a psa result 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)	$62.60
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)	$63.30
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	$134.80
66663	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$134.80
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	$37.40
66666	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$51.70
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test	$51.70
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test	$62.20
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	$67.80
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old	$18.70
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests	$140.00
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests	$125.50
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	$85.40
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)	$37.20
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)	$51.50

66697	Test described in item 66695, other than that described in 66696, if rendered by a receiving APP - each test to a maximum of 4 tests (Item is subject to rule 6 and 18)	$22.20
66698	2 tests described in item 66695 (Item is subject to rule 6)	$73.70
66701	3 tests described in item 66695 (Item is subject to rule 6)	$96.00
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)	$118.20
66707	5 or more tests described in item 66695 (Item is subject to rule 6)	$140.60
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)	$50.70
66712	Two tests described in item 66711 (Item is subject to rule 6)	$76.30
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)	$53.60
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	$30.60
66719	Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - free thyroxine, free t3, for a patient, if at least 1 of the following conditions is satisfied: (a) the patient has an abnormal level of tsh; (b) the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function (Item is subject to rule 9)	$42.50
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)	$63.90
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)	$63.90
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)	$22.20
66725	TSH quantitation described in item 66716 and 2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA)(Item is subject to rule 6)	$86.00
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)	$108.10
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)	$130.30
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,	$152.50

	performs 6 or more tests specified on the request form)(Item is subject to rule 6)	
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751	$37.40
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	$62.20
66750	Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total hcg), free alpha human chorionic gonadotrophin (free alpha hcg), free beta human chorionic gonadotrophin (free beta hcg), pregnancy associated plasma protein a (papp-a), unconjugated oestriol (ue3), alpha- fetoprotein (afp) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - (Item is subject to rule 25)	$76.40
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25)	$104.30
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	$41.60
66755	2 or more tests described in item 66752	$65.60
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.	$165.70
66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type.	$165.70
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests	$41.60
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick)	$22.20
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces except by reagent strip or dip stick methods)with a maximum of 3 examinations on specimens collected on separate days in a 28 day period	$15.00
66767	2 examinations described in item 66764 performed on separately collected and identified specimens	$30.00
66770	3 examinations described in item 66764 performed on separately collected and identified specimens	$45.10
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)	$30.10
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	$30.10
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA)or serotonin quantitation - 1 or more tests	$67.40
66780	A test described in item 66779 if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$67.40
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests	$24.90
66783	A test described in item 66782 if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$22.20

66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test (Item is subject to rule 6)	$67.40
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests (Item is subject to rule 6)	$111.10
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)	$67.40
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)	$43.70
66791	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests	$125.50
66792	A test described in item 66791 if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$125.50
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, phenabarbitone, primidone, phenytoin, procainamide, quinidine, salicylate, theophylline, tobramycin, valproate or vancomycin - 1 test (Item to be subject to rule 6)	$31.70
66803	2 tests described in item 66800 (Item is subject to rule 6)	$53.30
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)	$30.50
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)	$20.80
66806	3 tests described in item 66800 (Item is subject to rule 6)	$76.00
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)	$58.60
66815	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same apa, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate apa) (Item is subject to rule 6)	$100.40
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)	$58.60
66817	A test described in item 66812, other than that described in 66816, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18)	$41.70
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)	$51.70
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)	$51.70
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)	$36.70
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)	$88.30
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)	$51.70

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)	$51.70
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)	$36.70
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)	$88.30
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)	$103.80
66831	Quantitation of copper or iron in liver tissue biopsy	$54.20
66832	A test described in item 66831 if rendered by a receiving app (item is subject to rule 18a and 22)	$52.20
66900	Carbon-labelled urea breath test using c-13 or c-14 urea, including the measurement of exhaled 13co2 or 14co2 (except if item 12533 applies) for either:- (a) the confirmation of helicobacter pylori colonisation. or (b) the monitoring of the success of eradication of helicobacter pylori	$130.80

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	$18.50
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	$37.10
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	$55.30
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens	$80.30
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	$55.30
69316	Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26)	$48.30
69317	1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26)	$60.50
69318	Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed): (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	$55.30
69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26)	$72.30
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-	$86.00

	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	
69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	$71.80
69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18)	$72.50
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	$140.60
69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18)	$143.20
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	$213.20
69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18)	$215.80
69333	urine examination (including serial examination) by any means other than simple culture by dip slide, including:(a) cell count; and(b) culture; and(c) colony count; and(d) (if performed) stained preparations; and(e) (if performed) identification of cultured pathogens; and(f) (if performed) antibiotic suseptibility testing; and(g) (if performed) examination for ph, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts	$34.70
69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service mentioned in item 69300 - 1 of this item in any 7 day period	$56.30
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	$23.30
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	$89.20
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	$43.60
69357	2 sets of cultures described in item 69354	$87.10
69360	3 sets of cultures described in item 69354	$130.40
69363	Detection of Clostridium difficile or Clostridium difficile toxin (except if a service described in items 69345, 69369, 69370, 69373 or 69375 has been performed) - 1 or more tests	$42.20
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	$303.70

69379	A test described in item 69378 if rendered by a receiving APP -1 or more tests (Item is subject to rule 18)	$303.70
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:at presentation; or before antiretroviral therapy: orwhen treatment with combination antiretroviral agents fails;maximum of 2 tests in a 12 month period	$1,254.30
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	$303.70
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	$303.70
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)	$303.70
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)	$26.40
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) (Item is subject to rule 6)	$49.00
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) (Item is subject to rule 6)	$71.00
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 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)	$89.50
69396	5 or more tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA.) (Item is subject to rule 6)	$108.00
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)	$26.40
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)	$22.50
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	$26.40
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	$49.00
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	$71.50

	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	
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	$93.90
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 Hepatitus b, Hepatitus c antibody, hiv antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$108.00
69418	A test for high risk human papillomaviruses (hpv) in a patient who: - has received excisional or ablative treatment for high grade squamous intraepithelial lesions (hsil) of the cervix within the last two years; or - who within the last two years has had a positive hpv test after excisional or ablative treatment for hsil of the cervix; or - is already undergoing annual cytological review for the follow-up of a previously treated hsil. - to a maximum of 2 of this item in a 24 month period (Item is subject to rule 25)	$107.10
69419	A test described in item 69418 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)	$107.10
69445	Detection of Hepatitis c viral rna in a patient undertaking antiviral therapy for chronic hcv hepatitis (including a service described in item 69499) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 25)	$155.40
69451	A test described in item 69445 if rendered by a receiving APP - 1 test. (Item is subject to rule 18 and 25)	$155.40
69471	test of cell-mediated immunity in blood for the detection of latent tuberculosis in an immunosuppressed or immunocompromised patient - 1 test	$58.70
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test	$26.40
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests	$48.30
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)	$26.40
69478	2 tests described in 69475 (item subject to rule 11)	$49.30
69481	Investigation of infectious causes of acute or chronic hepatitis - 3 tests for hepatitis antibodies or antigens, (item subject to rule 11)	$68.30
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)	$256.40
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)	$256.40
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)	$28.70
69488	Quantitation of hcv rna load in plasma or serum in the pretreatment evaluation or the assessment of efficacy of antiviral therapy of a patient with chronic hcv hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician	$303.70

	who manages the treatment of the patient with chronic hcv hepatitis (including a service in item 69499 or 69445) (Item is subject to rule 18 and 25)	
69489	A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25)	$303.70
69491	Nucleic acid amplification and determination of Hepatitis c virus (hcv) genotype if: (a) the patient is hcv rna positive and is being evaluated for antiviral therapy of chronic hcv hepatitis; and (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; To a maximum of 1 of this item in a 12 month period	$345.30
69492	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)	$345.30
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)	$48.30
69495	2 tests described in 69494 (Item is subject to rule 6 and 26)	$60.50
69496	3 or more tests described in 69494 (Item is subject to rule 6 and 26)	$72.50
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)	$48.30
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)	$12.20
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)	$155.40
69500	A test described in item 69499 if rendered by a receiving APP 1 test (Item is subject to rule 18,19 and 25)	$155.40

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	$59.90
71058	Examination as described in item 71057 of 2 or more specimen types	$84.70
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)	$49.20
71060	Examination as described in item 71059 of 2 or more specimen types	$73.70
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	$73.70
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests	$35.10
71066	Quantitation of total immunoglobulin a by any method in serum, urine or other body fluid - 1 test	$24.60
71068	Quantitation of total immunoglobulin g by any method in serum, urine or other body fluid - 1 test	$24.60
71069	2 tests described in items 71066, 71068, 71072 or 71074	$27.70

71071	3 or more tests described in items 71066, 71068, 71072 or 71074	$37.90
71072	Quantitation of total immunoglobulin m by any method in serum, urine or other body fluid - 1 test	$24.60
71073	Quantitation of all 4 immunoglobulin G subclasses	$129.50
71074	Quantitation of total immunoglobulin d by any method in serum, urine or other body fluid - 1 test	$24.60
71075	Quantitation of immunoglobulin e (total), 1 test. (Item is subject to rule 25)	$28.00
71076	A test described in item 71073 if rendered by a receiving APP - 1 test(Item is subject to rule 18)	$178.90
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)	$45.60
71079	Detection of specific immunoglobulin e antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25)	$45.20
71081	Quantitation of total haemolytic complement	$68.20
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test	$24.60
71085	2 tests described in item 71083	$35.40
71087	3 or more tests described in item 71083	$47.40
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)	$35.60
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)	$49.10
71091	2 tests described in item 71089 (Item is subject to rule 6)	$64.60
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)	$39.90
71093	3 or more tests described in item 71089 (Item is subject to rule 6)	$93.30
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	$68.30
71096	A test described in item 71095 if rendered by a receiving APP, (Item is subject to rule 18)	$68.30
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required	$29.80
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method	$32.30
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids	$21.20
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service)	$63.50
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required	$19.10
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody	$21.20
71121	Detection of 2 antibodies specified in item 71119	$25.40
71123	Detection of 3 antibodies specified in item 71119	$29.60
71125	Detection of 4 or more antibodies specified in item 71119	$33.80

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	$215.30
71129	2 tests described in item 71127	$265.90
71131	3 or more tests described in item 71127	$316.60
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	$17.50
71134	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)	$175.40
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	$253.80
71137	Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, 1 of this item to a maximum of 2 in a 12 month period	$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	$127.10
71141	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens	$240.90
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	$317.30
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	$543.70
71146	Enumeration of cd34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pherisis collection	$175.40
71147	HLA-B27 typing (Item is subject to rule 27)	$68.30
71148	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27)	$68.30
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	$132.10
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	$145.10
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	$42.20

	subject to rule 6 and 23)	
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)	$58.30
71155	Detection of 2 antibodies described in item 71153 (item is subject to rule 6 and 23)	$57.90
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)	$21.80
71157	Detection of 3 antibodies described in item 71153 (item is subject to rule 6 and 23)	$73.70
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23)	$89.30
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	$41.70
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed)	$67.30
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)	$58.30
71166	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6)	$79.90
71167	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6)	$101.70
71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6)	$123.40
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)	$58.30
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)	$21.80
71180	Antibody to cardiolipin or beta-2 glycoprotein i detection, including quantitation if required; one antibody specificity (igg or igm)	$58.30
71183	Detection of two antibodies described in item 71180	$79.90
71186	Detection of three or more antibodies described in item 71180	$101.70
71189	Detection of specific igg antibodies to 1 or more respiratory disease allergens not elsewhere specified.	$26.10
71192	2 items described in item 71189.	$47.90
71195	3 or more items described in item 71189.	$67.50
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.	$68.30
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.	$61.40
71203	Determination of hlab5701 status by flow cytometry or cytotoxity assay prior to the initiation of abacavir therapy including item 73323 if performed.	$68.30

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)	$133.00

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)	$145.60
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)	$163.30
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (item is subject to rule 13)	$194.00
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13)	$180.30
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)	$201.40
72825	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 to 7 separately identified specimens (Item is subject to rule 13)	$312.90
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)	$369.50
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)	$368.20
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)	$379.40
72836	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13)	$618.60
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)	$772.90
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	$55.30
72846	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies (Item is subject to rule 13) except those listed in 72848	$80.10
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)	$122.20
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)	$109.90

72849	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 7-10 antibodies (item is subject to rule 13)	$139.50
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)	$158.90
72851	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13)	$273.20
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13)	$375.60
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)	$295.00
72856	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 2 to 4 separately identified specimens (Item is subject to rule 13)	$391.40
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)	$544.50

GROUP P6 - CYTOLOGY

73043	Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests	$36.20
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests	$73.70
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells	$153.70
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 1 identified site	$103.60
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	$306.00
73053	Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination (a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or (b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a) or (c) if there is inadequate information provided to use item 73055;	$32.80
73055	Cytology of a smear from cervix, not associated with item 73053, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test (a) for the management of previously detected abnormalities including precancerous or cancerous conditions; or (b) for the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia;	$32.80
73057	Cytology of smears from vagina, not associated with item 73053 or 73055 and not to monitor hormone replacement therapy, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test	$32.80
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with	$72.40

	multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061(item is subject to rule 13)	
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 to 6 antibodies(item is subject to rule 13)	$84.70
73061	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 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)	$93.50
73062	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 2 or more separately identified sites.	$150.00
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	$167.50
73064	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 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)	$120.90
73065	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 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)	$145.00
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	$360.60
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	$210.20

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	$732.50
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	$605.10
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.	$665.00
73291	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue ina) 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; orb) studies of a relative for an abnormality previously identified in such an affected person.- 1 or more tests.	$389.30
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	$994.20

	abnormalities (including a service in items 73287, 73289 or 73291, if performed)- 1 or more tests.	
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.	$389.30
73294	Analysis of the pmp22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as:a) diagnostic studies of an affected person; orb) studies of a relative for an abnormality previously identified in an affected person- 1 or more tests.	$389.30
73300	Detection of mutation of the fmr1 gene where:(a) the patient exhibits intellectual disability, ataxia, neurodegeneration, or premature ovarian failure consistent with an fmr1 mutation; or(b) the patient has a relative with a fmri mutation 1 or more tests	$170.60
73305	Detection of mutation of the fmr1 gene by Southern Blot analysis where the results in item 73300 are inconclusive	$341.60
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	$61.50
73309	A test described in item 73308, if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$61.50
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	$61.50
73312	A test described in item 73311, if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$61.50
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;	$389.40
73315	A test described in item 73314, if rendered by a receiving APP - 1 or more tests(Item is subject to rule 18)	$389.40
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)	$61.50
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)	$61.50
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)	$68.30
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)	$68.30
73323	Determination of hlab5701 status by molecular techniques prior to the initiation of abacavir therapy including item 71203 if performed.	$68.30
73324	A test described in item 73323 if rendered by a receiving app1 or more tests(item is subject to rule 18)	$69.20
73325	Characterisation of mutations in:(a) the jak2 gene; or (b) the mpl gene; or(c) both genes;in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of:a) polycythaemia vera; orb) essential thrombocythaemia;1 or more tests	$121.30

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; orb) idiopathic hypereosinophilic syndrome; orc) chronic eosinophilic leukaemia; 1 or more tests	$376.10
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	$84.60
73328	A test of tumour tissue from a patient with locally advanced or metastatic non-small cell lung cancer requested by, or on behalf of, a specialist or consultant physician to determine if the requirements relating to epidermal growth factor receptor (egfr) gene status for access to gefitinib under the pharmaceutical benefits scheme (pbs) are fulfilled.	$646.90
73330	A test of tumour tissue from a patient with metastatic colorectal cancer requested by, or on behalf of, a specialist or consultant physician to determine if the requirements relating to kirsten ras (kras) gene mutation status for access to cetuximab under the pharmaceutical benefits scheme (pbs) are fulfilled.	$376.10
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.	$513.50
73333	Detection of germline mutations of the von hippel-lindau (vhl) gene:in a patient who has a clinical diagnosis of vhl syndrome and:a family history of vhl syndrome and one of the following: haemangioblastoma (retinal or central nervous system); phaeochromocytoma; renal cell carcinoma; or2 or more haemangioblastomas; orone haemangioblastoma and a tumour or a cyst of: the adrenal gland; or the kidney; orthe pancreas; or the epididymis; or a broad ligament (other than epididymal and single renal cysts, which are common in the general population); orin 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	$920.70
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	$521.70
73335	Detection of somatic mutations of the von hippel-lindau (vhl) gene in a patient with: 2 or more tumours comprising: 2 or more haemangioblastomas, or one haemangioblastoma and a tumour of:the adrenal gland; orthe kidney; orthe pancreas; orthe epididymis; and no germline mutations of the vhl gene identified by genetic testing	$721.20

GROUP P8 - INFERTILITY AND PREGNANCY TESTS

73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test)	$18.40
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	$53.80
73527	Human chorionic gonadotrophin (hcg) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests	$16.90
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	$48.30

GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS

73801	Semen examination for presence of spermatozoa	$13.10

73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test	$7.70
73803	2 tests described in item 73802	$10.70
73804	3 or more tests described in item 73802	$13.80
73805	Microscopy of urine, whether stained or not, or catalase test	$7.90
73806	Pregnancy test by 1 or more immunochemical methods	$17.10
73807	Microscopy for wet film other than urine, including any relevant stain	$11.80
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	$4.00
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites	$15.20
73811	Mantoux test	$20.90

GROUP P10 - PATIENT EPISODE INITIATION

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	$4.10
73922	Initiation of a patient episode that consists of a service described in item 73053, 73055 or 73057 (in circumstances other than those described in item 73923).	$14.20
73923	Initiation of a patient episode that consists of a service described in items 73053, 73055 or 73057 if: (a) the person who is a private patient in a recognised hospital: or (b) the person receives the service from a prescribed laboratory	$4.10
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.	$25.70
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.	$4.20
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.	$13.80
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.	$4.10
73928	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item73920 or 73929 applies	$10.00
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	$4.10
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	$15.20

	approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital. Unless item 73931 applies	
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	$4.20
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	$17.30
73933	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in the place where the person is residing	$4.10
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	$29.80
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	$4.10
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.	$10.10
73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or73926), if the specimen is collected from the person by the person and if:the service is performed in a prescribed laboratory or the person is a private patient in a recognised hospital	$4.10
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	$13.50
73939	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if:the service is performed in a prescribed laboratory orthe person is a private patient in a recognised hospital	$4.10

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)	$17.30

SCHEDULE 1B—SCALE OF CHARGES—WORKERS COMPENSATION CHARGES

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

- Printed on A4 size paper
- Addressed specifically to the report requestor
- All margins to be no more than 2.5cms
- Line spacing of no more than 1.5 lines
- Font size no more than 12 pt
- Signed by the provider of the report.

Item	Description	Max Fee (excl GST)
REHABILITATION AND RETURN TO WORK PLANS		
RRTWG	General practitioners: reviewing and signing of a rehabilitation and return to work plan, expected to be provided within 10 business days of receipt of the initial request.	$62.50
RRTWR	Consultant physicians, specialists in a surgical discipline: reviewing and signing of a rehabilitation and return to work plan, expected to be provided within 10 business days of receipt of the initial request.	$122.90
	Note 1: A rehabilitation and return to work plan must be requested by a: - claims agent or self-insured employer - workplace rehabilitation 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.	$96.30
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.	$122.90
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.	$122.90
	Note 1: A short medical report must be requested in writing and may be requested by a: - claims agent 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 agent 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.	$250.60
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.	$469.70
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.	$469.70

Note 1: A standard medical report must be requested in writing and may be requested by a:
- claims agent 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 agent 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.	$313.30
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.	$588.90
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.	$588.90

Note 1: A complex medical report must be requested in writing and may be requested by a:
- claims agent 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 agent and clarified.

Note 4: A complex medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70 or WMS70. Consultation items in Schedule 1A must not be used for this purpose.

Note 5: A complex medical report requires additional information above that required in a standard report, and may be deemed complex compared to a standard report when the worker has:
- three or more ongoing compensable injuries arising from the same claim
- pre-existing conditions that have a significant impact on the compensable disability
- co-morbidities that have a significant impact on the compensable disability.

Note 6: Payment will only be made following submission of the report.

STANDARD MEDICAL REPORT - TREATING PSYCHIATRIST

WMY43 Psychiatrists: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. $588.90

Note 1: A standard medical report must be requested in writing and may be requested by a:
- claims agent 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 agent 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. $733.00

Note 1: A complex medical report must be requested in writing and may be requested by a:
- claims agent 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 agent 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 practitioners: Consultation, medical review for the preparation of a treating doctor report.	$57.40
WMP70	Consultant physicians: Consultation, medical review for the preparation of a treating doctor report.	$114.90
WMS70	Specialists in a surgical discipline: Consultation, medical review for the preparation of a treating doctor report.	$114.90
WMY73	Psychiatrists: Consultation, medical review for the preparation of a treating doctor report.	$318.90

READING TIME TO PREPARE A REPORT - TREATING DOCTOR

WMG55	General practitioners: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMG55 is $57.40 for reading time up to and including 12 pages, plus $4.90 per page thereafter.	DF
WMP55	Consultant physicians: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMP55 is $114.90 for reading time up to and including 12 pages, plus $9.10 per page thereafter.	DF
WMS55	Specialists in a surgical discipline: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMS55 is $114.90 for reading time up to and including 12 pages, plus $9.10 per page thereafter.	DF
WMY55	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 $149.30 for reading time up to and including 12 pages, plus $9.10 per page thereafter.	DF

Note 1: Payment for reading of written material will only be made where the reading is required in order for the doctor to prepare a report, and where the reading is at the request or approval of a:
- claims agent 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.	$56.40
WMP25	Consultant physicians: Clarification of a medical report, re-examination not required.	$102.50
WMS25	Specialists in a surgical discipline: Clarification of a medical report, re-examination not required.	$102.50

Note 1: Clarification of a medical report must be requested in writing and may be requested by a:
- claims agent 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.	$250.60 per hour
WMP24	Consultant physicians: Telephone call up to and including 60 minutes duration.	$491.10 per hour
WMS24	Specialists in a surgical discipline: Telephone call up to and including 60 minutes duration.	$491.10 per hour

Note 1: Telephone contact between treating/referring medical providers which forms part of the clinical management of the case is not chargeable.

Note 2: Telephone calls are chargeable if of a case specific nature, made to or received from a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative or advocate
- WorkCover medical consultant
- workplace rehabilitation provider.

Note 3: There is no charge for a telephone call to or from a worker.

Note 4: 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 5: 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 6: 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.	$250.60 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.	$491.10 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.	$491.10 per hour

Note 1: A case conference may be requested by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative
- workplace rehabilitation provider
- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent 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 agent or self-insured employer. It is the responsibility of the claims agent, 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.	$250.60 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.	$491.10 per hour
WMS08	Specialists 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.	$491.10 per hour

Note 1: A worksite assessment may be requested by a:
- claims agent 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 agent or self-insured employer representative should be present.

Note 3: The claims agent 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.	$250.60 per hour
WMP14	Consultant physicians: Third party consultation at the doctor's rooms where the worker is usually not present.	$491.10 per hour
WMS14	Specialists in a surgical discipline: Third party consultation at the doctor's rooms where the worker is usually not present.	$491.10 per hour

Note 1: A third party consultation must involve at least one of the following:
- claims agent 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
- workplace rehabilitation 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 agent 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.	$250.60 per hour
WMP15	Consultant physicians: Attendance at a dispute resolution.	$491.10 per hour
WMS15	Specialists in a surgical discipline: Attendance at a dispute resolution.	$491.10 per hour

Note 1: Attendance at a dispute resolution must be at the request of a:
- claims agent 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.	$250.60 per hour
WMP10	Consultant physicians: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$491.10 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.	$491.10 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.	$250.60 per hour
WMP36	Consultant physicians: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$491.10 per hour
WMS36	Specialists in a surgical discipline: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$491.10 per hour

Note 1: Payment for cancellation will only be made when the attendance was at the request of a:
- claims agent 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 24 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.	$96.30
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.	$122.90
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.	$122.90

Note 1: A job analysis and/or job description statement must be requested in writing and may be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate
- workplace rehabilitation 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.	$22.10
WMP23	Consultant physicians: Completion of a specified duties form.	$22.10
WMS23	Specialists in a surgical discipline: Completion of a specified duties form.	$22.10

Note 1: This form is to be completed at the request of a:
- claims agent 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.

Note 3: Specified duties forms can be obtained by contacting WorkCover on 13 18 55.

PHOTOCOPYING

WMGSP	General practitioners, consultant physicians, specialists in a surgical discipline: Photocopying of documents.	$0.20 per page

Note 1: A fee is only payable if the photocopying is at the request of a:
- claims agent 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.

Note 4: Accounts for administration time are not billable as this cost has been factored into the fee per page.

TRAVEL TIME - EMERGENCY ATTENDANCE

WMG58	General practitioners: Travel time, for the purpose of an initial emergency attendance of a	$250.60

	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.	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. 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.	$364.60 per hour

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).	$491.10 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. 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.	$711.70 per hour

EXTRA-CORPOREAL SHOCK WAVE THERAPY

WMI11	Specialists: Initial treatment of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$140.40
WMI12	Specialists: Subsequent treatments of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$114.90
WMI13	Specialists: Double treatments (bilateral or multiple) of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice. 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 WorkCover 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 agent authorisation prior to the provision of the service. Note 4: Epicondylitis treatment is NOT payable by WorkCover for treatment provided within three months or after five years from date of injury.	$191.40

SERVICES DELIVERED BY EAR, NOSE AND THROAT SURGEONS

WME24	Otorhinolaryngologists: Cortical evoked response audiometry - verification.	$327.10
WME2A	Otorhinolaryngologists: Cortical evoked response audiometry - quantification.	$327.10
WME25	Otorhinolaryngologists: Sensonics smell identification test.	$142.10

SERVICES DELIVERED BY MEDICAL PRACTITIONERS

WMG26	Medical practitioners: Fluids, intravenous drip infusion of - percutaneous.	$56.20
WMG27	Medical practitioners: Fluids, intravenous drip infusion of - open exposure.	$93.10

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

WMG31	Hypnotherapy at consulting rooms, not more than 15 minutes.	$48.30
WMG28	Hypnotherapy at consulting rooms, 16 to 30 minutes.	$83.70
WMG29	Hypnotherapy at consulting rooms, 31 to 45 minutes.	$125.80
WMG30	Hypnotherapy at consulting rooms, more than 46 minutes.	$171.30

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.	$122.90
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.	$122.90

Note 1: A short medical report must be requested in writing and may be requested by a:
- claims agent 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 agent 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.	$588.90

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.	$588.90

Note 1: A medical report must be requested in writing and may be requested by a:
- claims agent 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 agent 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.	$733.00

Note 1: A psychiatrists medical report must be requested in writing and may be requested by a:
- claims agent 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 agent 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: Consultation, medical review for the preparation of an independent medical examiner report.	$223.30
WMS80	Specialists in a surgical discipline: Consultation, medical review for the preparation of an independent medical examiner report.	$223.30
WMY83	Psychiatrists: Consultation, medical review for the preparation of an independent medical examiner report.	$318.90

INDEPENDENT MEDICAL EXAMINER - READING TIME

WMP32	Consultant physicians: Reading time payable to an independent medical examiner for reading prior reports or other information forwarded or approved by the requestor in	DF

order to prepare a report.
Derived fee: The fee for item WMP32 is $114.90 for reading time up to and including 12 pages, plus $9.10 per page thereafter.

WMS32	Specialists in a surgical discipline: 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 $114.90 for reading time up to and including 12 pages, plus $9.10 per page thereafter.	DF
WMY32	Psychiatrists: 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 $149.30 for reading time up to and including 12 pages, plus $9.10 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 agent 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: Clarification of a medical report, re-examination not required.	$102.50
WMS33	Specialists in a surgical discipline: Clarification of a medical report, re-examination not required.	$102.50

Note 1: A clarification of a medical report must be requested in writing and may be requested by a:
- claims agent 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: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$491.10 per hour
MS940	Specialists in a surgical discipline: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$491.10 per hour

Note 1: Travel will be approved for independent medical examiner services requested by a:
- claims agent 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: non-attendance at, or cancellation less than 48 hours (excluding weekends and public hospitals in South Australia) before an appointment.	$223.30
WMS34	Specialists in a surgical discipline: non-attendance at, or cancellation less than 48 hours (excluding weekends and public holidays in South Australia) before an appointment.	$223.30
WMY88	Psychiatrists: non-attendance at, or cancellation less than 48 hours (excluding weekends and public holidays in South Australia) before an appointment.	$318.90

Note 1: Fees apply only to the cancellation of medical appointments arranged by a:
- claims agent 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: 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.	$143.60
WMS64	Specialists in a surgical discipline: 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.	$143.60
WMP65	Consultant physicians: Cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$229.70
WMS65	Specialists in a surgical discipline: Cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$229.70
WMP66	Consultant physicians: Overnight accommodation including meals and incidentals.	$304.30
WMS66	Specialists in a surgical discipline: Overnight accommodation including meals and incidentals.	$304.30
WMP67	Consultant physicians: Travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor.	ATO Rates
WMS67	Specialists in a surgical discipline: Travel by motor vehicle, to and from a venue for the	ATO Rates

purposes of an appointment made by the report requestor.

WMP68	Consultant physicians: Travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor.	Economy Airfare
WMS68	Specialists in a surgical discipline: 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 WorkCover to be the reasonable cost of undertaking the travel using a standard economy airfare.

PERMANENT IMPAIRMENT ASSESSMENTS

In accordance with Section 43A of the *Workers Rehabilitation and Compensation Act 1986,* only legally qualified medical practitioners who hold a current accreditation issued by WorkCoverSA can provide these services.

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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$501.20
PIA30	Specialists: permanent impairment assessor standard report, simple assessment of one body system - reading, examination and report in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.	$982.30

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 7: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$626.50
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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$1,228.10

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 7: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

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 - reading, examination and report in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.	$793.60
PIA32	Specialists: permanent impairment assessor complex report, complex assessment on a single body system or multiple injuries involving more than one body system - reading, examination and report in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.	$1,555.50

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 7: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$982.30

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the item listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 7: '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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$626.50
PIA33	Specialists: 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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$1,228.10

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 7: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 8: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$751.60
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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$1,473.60

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 7: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 8: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

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 - reading, examination conducted with the assistance of an interpreter and	$919.10

report in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

PIA35	Specialists: permanent impairment assessor complex report with interpreter, complex assessment on a single body system or multiple injuries involving more than one body system - reading, examination conducted with the assistance of an interpreter and report in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.	$1,801.10

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 7: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 8: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

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 WorkCover Guidelines for the Evaluation of Permanent Impairment.	$1,228.10

Note 1: Reports will be requested by a:
- claims agent or self-insured employer
- worker, worker's representative or advocate.

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: Only permanent impairment assessors accredited by WorkCover are entitled to payment for the items listed above.

Note 4: The examination and the preparation of a report must be in accordance with the WorkCover Guidelines for the Evaluation of Permanent Impairment.

Note 5: Reports are to be provided to the requestor 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 6: If an interpreter is present at the examination, the medical fee payable is in accordance with the fee set out above.

Note 7: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with the requirements of, the WorkCover Guidelines for the evaluation of permanent impairment.

Note 8: '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.	$180.30
PIA36	Specialists: 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.	$353.80

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.	$125.30
PIA37	Specialists: permanent impairment assessor supplementary report, where additional information is requested by the report requestor.	$245.60

Note 1: Supplementary report fees are not payable if additional work is required as a result of an obvious error or omission on the part of the assessor.

PERMANENT IMPAIRMENT ASSESSOR - ADDITIONAL READING TIME

PIA18	General practitioners: permanent impairment assessor additional reading time in conjunction with a standard or moderately complex report. The fee is only to be charged if there are more than 25 pages of reading material supplied by the report requestor. The first 25 pages are included in the report fee and are therefore not chargeable under this item. Derived fee: $4.90 per page over 25 pages.	DF
PIA38	Specialists: 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: $9.10 per page over 25 pages.	DF
PIA19	General practitioners: permanent impairment assessor additional reading time in conjunction with a complex report. This fee is only to be charged if there are more than 51 pages of reading material supplied by the report requestor. The first 51 pages are included in the report fee and are therefore not chargeable under this item. Derived fee: $4.90 per page over 51 pages.	DF
PIA39	Specialists: 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: $9.10 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, notice of disability, full page of handwritten notes.

PERMANENT IMPAIRMENT ASSESSOR - TRAVEL FOR EXAMINATIONS

PIA60	General practitioners or specialists: 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	$143.60
PIA62	General practitioners or specialists: permanent impairment assessor - cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$229.70
PIA64	General practitioners or specialists: permanent impairment assessor accommodation - overnight accommodation including meals and incidentals.	$304.30
PIA66	General practitioners or specialists: 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: permanent impairment assessor aircraft travel - travel by aircraft, to and from a venue for the purpose of an appointment made by the report requestor.	Economy Airfare

Note 1: The first 50 kilometres of any travel is not chargeable.

Note 2: If an assessor is travelling for the purpose of conducting more than one permanent impairment assessment, the travel fees must be apportioned accordingly.

Note 3: 'A full day' as per item PIA60 refers to a stay of more than 5 hours at the venue including travel time.

Note 4: ATO rates means the rate, applicable to the type of motor vehicle in which the assessor travelled, published by the Australian Taxation Office as the rate per kilometre that may be claimed as a deduction for business travel expenses incurred in the previous financial year.

Note 5: Economy airfare means the amount determined by WorkCover 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 Guidelines.

Item	Description	Max Fee (excl GST)
CONSULTATIONS		
CH001	Short initial consultation of not more than 20 minutes duration.	$41.50
CH002	Initial consultation of more than 20 minutes but not more than 30 minutes duration.	$69.20
CH003	Initial consultation of more than 30 minutes but not more than 45 minutes duration.	$103.90
CH042	Standard subsequent consultation of more than 10 minutes but not more than 30 minutes duration. The consultation will involve all aspects of a subsequent consultation, and because of the complexity of the injury, will require extra time for history taking, re-examination, treatment, documentation and liaison. For example, this type of consultation may be expected in cases of injuries following major trauma or major surgery requiring intensive post-operative treatment.	$47.10
CH043	Prolonged subsequent consultation of more than 30 minutes duration. The consultation will involve all aspects of a subsequent consultation, and because of the complexity of the injury, will require extra time for history taking, re-examination, treatment, documentation and liaison. This type of consultation is expected in only a limited number of cases, for example, in cases of injuries following multi-trauma, major surgery requiring intensive post-operative treatment such as complicated had injuries or joint reconstruction and some neurological conditions.	$96.90
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
CH780	Independent clinical assessment and report Services provided by a chiropractor other than the treating chiropractor comprising: (a) a review of the worker's medical history (b) a clinical assessment (c) a review of the worker's activity and functional capacity (d) preparation of a report, for the purpose of providing a differential diagnosis and/or making recommendations in relation to ongoing treatment/management services, functional goals, the worker's capacity to return to work and any other relevant matters and where appropriate, align future management with the guiding principles and expectations of the Clinical Framework. Note 1: An independent clinical assessment must be requested in writing by a: - claims agent or self-insured employer - worker or worker's representative. Treating medical experts may ask one of the above to request this service if deemed necessary. Note 2: This service cannot be performed by the treating chiropractor. The independent clinical assessor must remain independent in relation to treatment services during and following an independent clinical assessment. Note 3: An independent clinical assessment report must: (i) provide recommendations for further treatment/management (including referrals to other agencies) and the expected benefit to the worker. (ii) address all questions asked by the referrer and where any question cannot be answered, provide an explanation (iii) be limited to the relevant circumstances of the worker's injury/condition	$166.20 per hour

(iv) be based on appropriate clinical examination, assessment and review of reports
(v) be consistent with accepted clinical practice and based on objective clinical findings
(vi) be accurate, unbiased, precise and consistent
(vii) document any inability to obtain the worker's consent to any aspect of the assessment.

Note 4: Payment will only be made following submission of the report.

Note 5: Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: An independent clinical assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 5: All component activites (e.g. telephone calls, assessment, report etc.) undertaken to complete an independent clinical assessment and report must be accumulated then rounded to the nearest six minutes.

TRAVEL TIME

CH905	Travel time Travel by a chiropractor for the purposes of a: - a case conference - home, hospital or worksite visit - consultation where the client is otherwise unable to attend the chiropractor's clinic or rooms.	$141.10 per hour

Note 1: There is no charge for travel from one clinic or rooms to another clinic or rooms.

Note 2: Chiropractors who conduct regular sessional visits with particular hospitals, specialist practitioners or rehabilitation facilities may not charge for travel in these instances.

Note 3: Travel time is not included in any of the charges in the schedule and should be itemised separately on accounts for associated services.

Note 4: All account must include the total time spent travelling plus the distance travelled.

Note 5: Where a chiropractor provides services to multiple workers in a hospital or workplace, it is expected the travel charge will be divided accordingly.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TELEPHONE CALLS

CH552	Telephone calls greater than 3 minutes	$23.10 flat fee

Note 1: Telephone calls are chargeable if they are of a case specific nature, made to or received from the:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative
- WorkCover medical consultant
- workplace rehabilitation provider
- worker's referring/treating medical practitioner.

Note 2: Telephone calls are NOT chargeable if:
- made during a consultation
- made to or from a worker
- the call duration is three minutes or less.

Note 3: This communication should not replace expected communication methods and reports between treating or referring practitioners.

Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party.

Note 5: Telephone calls related to an independent clinical assessment (ICA) are chargeable under item number CH780.

TREATING CHIROPRACTOR REPORTS

CH820	Standard report A standard report is a clinical opinion, statement or response to questions relating to the status of the claim.	$166.20 flat fee

Note 1: A standard chiropractor report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A standard report should be based on the chiropractor's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example, if the chiropractor has not seen the patient for some time), a consultation fee may be charged using item number CH815.

Note 3: Payment will only be made following submission of the report.

CH810	Comprehensive report A comprehensive report is a clinical opinion, statement or response to questions relating to the status of the claim and requires additional information above that required by a standard report due to the complexity of the case. Complexity is defined as: - three or more ongoing compensable injuries arising from the same claim - pre-existing conditions that have a significant impact on the compensable injury - co-morbidities that have a significant impact on the compensable disability. The maximum time chargeable for this item is 2 hours.	$166.20 per hour

Note 1: A comprehensive report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A comprehensive report should be based on the chiropractor's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example, if the chiropractor has not seen the patient for some time), a consultation fee may be charged using item number CH815.

Note 3: Payment will only be made following submission of the report.

Note 4: Any part of an hour should be charged proportionately and rounded to the nearest six minutes.

CONSULTATION FOR PREPARING A TREATING CHIROPRACTOR REPORT

CH815	Consultation for the purposes of preparing a standard or comprehensive treating chiropractor report.	$47.10 flat fee

CASE CONFERENCE

CH870	Case conference Case conference attended by a chiropractor for the purpose of discussing:	$166.20 per hour

- details of limitations/recommendations relating to a sustainable return to work
- options for the management of a worker's recovery and functional restoration
- information relating to the suitable duties at the workplace
- barriers to return to work
- other related information.

Note 1: A case conference must be requested in writing by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative
- workplace rehabilitation provider
- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by a chiropractor during the case conference unless delegated as the representative by the claims agent or self-insured employer. It is the responsibility of the claims agent, 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: Travel may be charged separately in accordance with item number CH905.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY CHIROPRACTOR)

CHT11	Cervical spine - 2 views	$128.90
CHT13	Thoracic spine - 2 views	$109.60
CHT15	Lumbo-sacral spine - 3-6 views	$151.20
CHT16	Sacro-coccygeal area - 2 views	$91.30
CHT27	Hip joint	$98.50
CHT28	Pelvic girdle	$124.40

NON-SCHEDULED SERVICES

CH999	Non-scheduled services A service of a kind (other than a radiological service) not listed above, provided by a chiropractor and authorised by a claims agent or self-insured employer prior to the delivery of the service as being necessary, appropriate and reasonably required.	$166.20 per hour

Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

Note 2: Examples of activities and services that are not appropriate for reimbursement under item number CH999:
- electronic communications related to clinical consultations and other treatment services
- letters or reports that would normally be considered as part of a clinical consultation
- non-attendance or cancellation fees for treatment services
- photocopying.

SCHEDULE 3—SCALE OF CHARGES—OCCUPATIONAL THERAPY SERVICES

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

Item	Description	Max Fee (excl GST)
CONSULTATIONS		
OT105	Initial consultation (history, examination and treatment). An initial consultation by an occupational therapist involving some or all of the following elements: - clinical assessment - clinical treatment - graded activity/exercise - pain management - stress management - relaxation training - biomechanical education - independent living skills training. Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	$166.20 per hour
OT205	Subsequent consultation and treatment. A consultation by an occupational therapist involving some or all of the following elements: - clinical reassessment - clinical treatment - graded activity/exercise - pain management - stress management - relaxation training - biomechanical education - independent living skills training. Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	$166.20 per hour
CORRECTIVE/SERIAL SPLINTING		
	A splint is provided for correction and/or prevention of musculoskeletal imbalance. It may be prescribed to facilitate return to work or resumption of activities of daily living. A splint may be used as an adjunct to a treatment regime that includes corrective exercises/activities.	
OT300	Fabrication/fitting/adjustment of splint.	$166.20 per hour
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
OT780	Independent clinical assessment and report. Service provided by an occupational therapist other than the treating occupational therapist comprising: (a) a review of the worker's medical history (b) a clinical assessment (c) a review of the worker's activity and functional capacity (d) preparation of a report, for the purpose of providing a differential diagnosis and/or making recommendations in	$166.20 per hour

relation to ongoing treatment/management services, functional goals, the worker's capacity to return to work and any other relevant matters, and where appropriate, align future management with the guiding principles and expectations of the Clinical Framework.

Note 1: An independent clinical assessment must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.
Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: This service cannot be performed by the treating occupational therapist. The independent clinical assessor must remain independent in relation to treatment services during and following an independent clinical assessment.

Note 3: An independent clinical assessment report must:
(i) provide recommendations for further treatment/management (including referrals to other agencies) and the expected benefit to the worker
(ii) address all questions asked by the referrer and where any question cannot be answered, provide an explanation
(iii) be limited to the relevant circumstances of the worker's injury/condition
(iv) be based on appropriate clinical examination, assessment and review of reports
(v) be consistent with accepted clinical practice and based on objective clinical findings
(vi) be accurate, unbiased, precise and consistent
(vii) document any inability to obtain the worker's consent to any aspect of the assessment.

Note 4: Payment will only be made following submission of the report.

Note 5: Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: An independent clinical assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 5: All component activites (e.g. telephone calls, assessment, report etc.) undertaken to complete an independent clinical assessment and report must be accumulated then rounded to the nearest six minutes.

DRIVER ASSESSMENT, REHABILITATION AND REPORT

OTDVA	Driver assessment and report. The occupational therapy driver assessment aims to assist the worker with a functional impairment to commence or return to safe and independent driving through the identification of strengths and limitations, program planning for compensatory and remediation strategies, and the prescription of adaptive driver equipment and/or modifications. This does not automatically include driver rehabilitation service.	$166.20 per hour

Note 1: Referrals for a driver assessment must be requested in writing by a:
- claims agent or self-insured employer
- treating medical practitioner.
Any referral requested by a claims agent or self-insured employer must be made in collaboration with the treating medical practitioner. A referral by a claims agent can only be made to an occupational therapist who has an agreement with WorkCover.

Note 2: It is the responsibility of the occupational therapist to ensure that the worker has been certified as medically fit to drive for the purposes of undertaking the assessment.

Note 3: The driver trained occupational therapist is expected to provide a driver

assessment report to the claims agent and treating practitioner within 10 business days of undertaking the assessment.

Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

OTDVR Driver rehabilitation and report. $166.20 per hour

The occupational therapy driver rehabilitation service aims to, where safe and legal to do so, assist the worker with a functional impairment to commence, maintain or return to safe and independent driving through the development of an intervention plan which may include compensatory and rehabilitative strategies, and the prescription of adaptive driving equipment and/or modifications.

Note 1: Referrals for driver rehabilitation must be requested in writing by a:
- claims agent or self-insured employer
- treating medical practitioner.
A referral by a claims agent can only be made to an occupational therapist who has an agreement with WorkCover.

Note 2: An occupational therapy driver assessment has occurred and medical approval has been obtained.

Note 3: A final report is to be provided within 10 business days of completing the driver rehabilitation program.

Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TELEPHONE CALLS

OT552 Telephone call greater than 3 minutes. $23.10 flat fee

Note 1: Telephone calls are chargeable if they are of a case specific nature, made to or received from the:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative
- WorkCover medical consultant
- workplace rehabilitation provider
- the worker's referring/treating medical practitioner.

Note 2: Telephone calls are NOT chargeable if:
- made during a consultation
- made to or from a worker
- the call duration is three minutes or less.

Note 3: This communication should not replace expected communication methods and reports between treating or referring practitioners.

Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party.

Note 5: Telephone calls related to an independent clinical assessment (ICA) or medical expert rehabilitation services (MERS) are not chargeable under this item.

TREATING OCCUPATIONAL THERAPY REPORTS

OT820 Standard report. $166.20 flat fee

A standard report is a clinical opinion, statement or response to questions relating to the status of the claim.

Note 1: A standard report must be requested in writing by a:
- claims agent or self-insured employer

- worker or worker's representative.

Note 2: A standard report should be based on the occupational therapists notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example, if the occupational therapist has not seen the patient for some time), a consultation fee may be charged using item number OT815.

Note 3: Payment will only be made following submission of the report.

OT810	Comprehensive report. A comprehensive report is a clinical opinion, statement or response to questions relating to the status of a claim and requires additional information above that required by a standard report due to the complexity of the case. Complexity is defined as: - three or more ongoing compensable injuries arising from the same claim - pre-existing conditions that have a significant impact on the compensable injury - co-morbidities that have a significant impact on the compensable disability. The maximum time chargeable for this item is 2 hours.	$166.20 per hour

Note 1: A comprehensive report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A comprehensive report should be based on the occupational therapists notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example, if the occupational therapist has not seen the patient for some time), a consultation fee may be charged using item number OT815.

Note 3: Payment will only be made following submission of the report.

Note 4: Any part of an hour should be charged proportionately and rounded to the nearest six minutes.

CONSULTATION FOR PREPARING A TREATING OCCUPATIONAL THERAPY REPORT

OT815	Consultation for the purposes of preparing a standard or comprehensive treating occupational therapy report.	$166.20 flat fee

FUNCTIONAL ESTIMATION FORM

OT785	Functional estimation form. Completion of a functional estimation form (in a form approved by WorkCover) by an occupational therapist and provision of the form to a worker's certifying medical practitioner. The form is completed by a treating occupational therapist when information is identified from a clinical consultation that impacts on the worker's capacity to return to work.	$23.10 flat fee

CASE CONFERENCE

OT870	Case conference. Case conference, attended by an occupational therapist for the purpose of discussing: - details of limitations/recommendations relating to a sustainable return to work - options for the management of a worker's recovery and functional restoration - information relating to suitable duties at the workplace - barriers to return to work - other related information.	$166.20 per hour

Note 1: A case conference must be requested in writing by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative

- workplace rehabilitation provider
- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by an occupational therapist during the case conference unless delegated as the representative by the claims agent or self-insured employer. It is the responsibility of the claims agent, 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: Travel may be charged separately in accordance with item number OT905.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TRAVEL TIME

OT905 Travel time. $141.10 per hour

Travel by an occupational therapist for the purpose of a:
(a) case conference
(b) home, hospital or worksite visit
(c) consultation where the worker is otherwise unable to attend the occupational therapist's clinic or rooms.

Note 1: When an occupational therapist consults at more than on clinic, travel between clinics cannot be charged.

Note 2: Occupational therapists who conduct regular sessional visits with particular hospitals, specialist practitioners or rehabilitation facilities may not charge for travel in these instances.

Note 3: Travel time is not included in any of the charges in the schedule and should be itemised separately on accounts for associated services.

Note 4: All accounts must include the total time spent travelling plus the distance travelled.

Note 5: Where an occupational therapist provides services to multiple workers in a hospital or workplace, it is expected the travel charge will be divided accordingly.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

MEDICAL EXPERT REHABILITATION SERVICES

ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT

OT760 Activities of daily living assessment and report. $166.20 per hour

Assessment by an occupational therapist, usually conducted in a worker's home environment, to assess the worker's level of functioning in relation to personal care, household tasks and recreational and social activities.
The purpose of the assessment is to reduce the potential impact of the injury on the worker, to facilitate early return to normal activity, and to provide an indicator of functional tolerances for determining work capacity.

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer.
Treating medical experts may ask one of the above to request this service is deemed necessary.

Note 2: A visit is made to the home or hospital within five business days of receipt of written referral and/or approval by the treating medical practitioner, claims agent or self-insured employer or within a timeframe specified by the referrer.

Note 3: Reports written as a result of an activities of daily living assessment must be incorporated in the total charge for the service. They must not be charged using other occupational therapy report item numbers.

Note 4: A final report is to be provided within 10 business days of completing the activities of daily living assessment.

Note 5: Any time spent on communication directly related to an activities of daily living assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete an activities of daily living assessment and report must be accumulated then rounded to the nearest six minutes.

FUNCTIONAL CAPACITY EVALUATION AND REPORT

A functional capacity evaluation is undertaken to determine a worker's abilities over a range of physical demands in order to make recommendations for participation in work. The functional capacity evaluation is a standardised battery of tests used to evaluate a worker's capacity for work-related activities.

OT700	Functional capacity evaluation and report.	$166.20 per hour

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer.
Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A functional capacity evaluation should only be undertaken when the required information about capacity is not available through other means.

Note 3: The maximum time chargeable for this item is 7 hours. Invoices that exceed this amount will be returned for amendment.

Note 4: Report written as a result of a functional capacity evaluation must:
- include an executive summary outlining the major components of the service and relevant findings
- be incorporated in the total charge for the service. They must not be charged using other occupational therapy report item numbers.

Note 5: A final report is to be provided within 10 business days of completing the functional capacity evaluation.

Note 6: Any time spent on communication directly related to a functional capacity evaluation and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 7: A functional capacity evaluation and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 8: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a functional capacity evaluation and report must be accumulated then rounded to the nearest six minutes.

GRADUATED RETURN TO WORK PROGRAM AND REPORT

The purpose of this program is to maximise the worker's ability to return to work. The program will be highly structured, goal orientated and individualised for each worker.

OT750 Graduated return to work program and report. $166.20 per hour

The program will involve actual and productive work duties identified by the occupational therapist as being within the worker's capacity and work practice guidelines relevant to the nature of the worker's injury and the performance of the particular duties.

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer.
Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A medical clearance should be obtained prior to implementing the graduated return to work program.

Note 3: The program will not exceed 12 weeks unless an increase in capacity is demonstrated and the claims agent or self-insured employer approves an extension of the program.

Note 4: Reports written as a result of a graduated return to work program must be incorporated in the total charge for the service. They must not be charged using other occupational therapy report item numbers.

Note 5: A final report is to be provided within 10 business days of completing the graduated return to work program.

Note 6: Any time spent on communication directly related to a graduated return to work program and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a graduated return to work program and report must be accumulated then rounded to the nearest six minutes.

JOB ANALYSIS AND REPORT

OT740 Job analysis and report. $166.20 per hour

Attendance by an occupational therapist at a designated workplace to analyse available duties.

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer.
Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A job analysis includes:

(a) an analysis of the critical physical demands of available duties

(b) determining the worker's capacity to undertake the duties and individual tasks giving consideration to available medical guidelines, the occupational therapist's knowledge of the worker's diagnosis, pathology and prognosis, and other factors relevant to the worker's participation in work-related activities

(c) making recommendations regarding:

(i) modifications of duties and/or individual tasks

(ii) the provision of equipment, therapeutic aids or appliances

(iii) introducing work practice guidelines to ensure the worker utilises safe body mechanics.

(d) preparation of a report with an executive summary outlining the major components of the service and relevant findings.

Note 3: Reports written as a result of a job analysis must be incorporated in the total charge for the service. They must not be charged using other occupational therapy report item numbers.

Note 4: A final report is to be provided within 10 business days of completing the job analysis.

Note 5: Any time spent on communication diectly related to a job analysis and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: A job analysis and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a job anaylsis and report must be accumulated then rounded to the nearest six minutes.

WORKSITE ASSESSMENT AND REPORT

OT730 Worksite assessment and report. $166.20 per hour

Attendance by an occupational therapist at a designated workplace in order to obtain an overview of the workplace, the worker's current duties and determine the availability of suitable duties.

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer.
Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: The occupational therapist should visit the workplace within five working days of receipt of written referral or within a time specified by the referrer, subject to the employer's cooperation.

Note 3: Reports written as a result of a worksite assessment must be incorporated in the total charge for the service. They must not be charged using other occupational therapy report item numbers.

Note 4: A final report is to be provided within 10 business days of completing the worksite assessment.

Note 5: Any time spent on communication directly related to a worksite assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: A worksite assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a worksite assessment and report must be accumulated then rounded to the nearest six minutes.

NON-SCHEDULED SERVICES

OT999 Non-scheduled services. $166.20 per hour

A service of a kind not listed above provided by an occupational therapist and authorised by a claims agent or self-insured employer prior to the delivery of the service as being necessary, appropriate and reasonably required.

Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

Note 2: Examples of activities and services that are not appropriate for reimbursement under OT999:
- electronic communications related to clinical consultations and other treatment

services
- letters or reports that would normally be considered as part of a clinical consultation
- non-attendance or cancellation fees for treatment services
- functional capacity evaluation hire costs
- photocopying.

SCHEDULE 4—SCALE OF CHARGES—OSTEOPATHY SERVICES

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

Item	Description	Max Fee (excl GST)
CONSULTATIONS		
Initial consultations		
	Consultation by an osteopath involving the osteopath's attendance with the worker. The initial consultation may involve 2 separate attendances on the same day. For example, a second attendance might be required for the interpretation of test data (such as x-rays).	
OS111	Initial consultation, involving review of medical history, examination and treatment, of not more than 35 minutes duration.	$83.20
OS112	Initial consultation, involving review of medical history, examination and treatment, of not more than 1 hour duration.	$124.70
Subsequent consultations		
OS211	Standard subsequent consultation, involving review of medical history, examination and treatment, of not more than 15 minutes duration.	$41.50
OS212	Long subsequent consultation, involving review of medical history, examination and treatment, of not more than 35 minutes duration.	$83.20
OS213	Prolonged subsequent consultation, involving review of medical history, examination and treatment, of more than 35 minutes duration.	$96.90
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
OS780	Independent clinical assessment and report Services provided by an osteopath other than the treating osteopath comprising: (a) a review of the worker's medical history (b) a clinical assessment (c) a review of the worker's activity and functional capacity (d) preparation of a report for the purpose of providing a differential diagnosis and/or making recommendations in relation to ongoing treatment/management services, functional goals, the worker's capacity to return to work and any other relevant matters, and where appropriate, align future management with the guiding principles and expectations of the Clinical Framework. Note 1: An independent clinical assessment report must be requested in writing by a: - claims agent or self-insured employer - worker or worker's representative. Treating medical experts may ask one of the above to request this servcie if deemed necessary. Note 2: This service cannot to be performed by the treating osteopath. The independent clinical assessor must remain independent in relation to treatment services during and following an independent medical assessment.	$166.20 per hour

Note 3: An independent clinical assessment report must:
(i) provide recommendations for further treatment/management (including referrals to other agencies) and the expected benefit to the worker
(ii) address all questions asked by the referrer and where any question cannot be answered, provide an explanation
(iii) be limited to the relevant circumstances of the worker's injury/condition
(iv) be based on appropriate clinical examination, assessment and review of reports
(v) be consistent with accepted clinical practice and based on objective clinical findings
(vi) be accurate, unbiased, precise and consistent
(vii) document any inability to obtain the worker's consent to any aspect of the assessment.

Note 4: Payment will only be made following submission of the report.

Note 5: Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: An independent clinical assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 5: All component activites (e.g. telephone calls, assessment, report etc.) undertaken to complete an independent clinical assessment and report must be accumulated then rounded to the nearest six minutes.

TELEPHONE CALLS

OS552 Telephone calls greater than three minutes. $23.10 flat fee

Note 1: Telephone calls are chargeable if they are of a case specific nature, made to or received from the:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative
- WorkCover medical consultant
- workplace rehabilitation provider
- worker's referring/treating medical practitioner.

Note 2: Telephone calls are NOT chargeable if:
- made during a consultation
- made to or from a worker
- the call duration is three minutes or less.

Note 3: This communication should not replace expected communication methods and reports between treating or referring practitioners.

Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party.

Note 5: Telephone calls related to an independent clinical assessment (ICA) are chargeable under item number OS780.

TREATING OSTEOPATH REPORTS

OS820 Standard report $166.20 flat fee
A standard report is a clinical opinion, statement or response to questions relating to the status of the claim.

Note 1: A standard report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A standard report should be based on the osteopath's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example if the osteopath has not seen the patient for some time), a consultation fee may be charged using item number OS815.

Note 3: Payment will only be made following submission of the report.

OS810	Comprehensive report A comprehensive report is a clinical opinion, statement or response to questions relating to the status of the claim and requires additional information above that required by a standard report due to the complexity of the case. Complexity is defined as: - three or more ongoing compensable injuries arising from the same claim - pre-existing conditions that have a significant impact on the compensable injury - co-morbidities that have a significant impact on the compensable disability. Maximum time chargeable for this item is 2 hours.	$166.20 per hour

Note 1: A comprehensive report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A comprehensive report should be based on the osteopath's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example if the osteopath has not seen the patient for some time), a consultation fee may be charged using item number OS815.

Note 3: Payment will only be made following submission of the report.

Note 4: Any part of an hour should be charged proportionately and rounded to the nearest six minutes.

CONSULTATION FOR PREPARING A TREATING OSTEOPATH REPORT

OS815	Consultation for the purposes of preparing a standard or comprehensive osteopath report.	$41.50 flat fee

CASE CONFERENCE

OS870	Case conference Case conference attended by an osteopath for the purpose of discussing: - details of limitations/recommendations relating to a sustainable return to work - options for the management of a worker's recovery and functional restoration - information relating to suitable duties at the workplace - barriers to return to work - other related information.	$166.20 per hour

Note 1: A case conference must be requested in writing by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative
- workplace rehabilitation provider
- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by an osteopath during the case conference unless delegated as the representative by the claims agent or self-insured employer. It is the responsibility of the claims agent, 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: Travel may be charged separately in accordance with item number OS905.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TRAVEL TIME

OS905	Travel time Travel by an osteopath for the purposes of a: (a) case conference (b) home, hospital or worksite visit (c) consultation where the worker is otherwise unable to attend the osteopath's clinic or rooms.	$141.10 per hour

Note 1: There is no charge for travel from one clinic or rooms to another clinic or rooms.

Note 2: Osteopaths who conduct regular sessional visits with particular hospitals, specialist practitioners or rehabilitation facilities may not charge for travel in these instances.

Note 3: Travel time is not included in any of the charges in the schedule and should be itemised separately on accounts for associated services.

Note 4: All accounts must include the total time spent travelling plus the distance travelled.

Note 5: Where an osteopath provides services to multiple workers in a hospital or workplace, it is expected the travel charge will be divided accordingly.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY OSTEOPATH)

OST11	Cervical spine - 2 views	$128.90
OST13	Thoracic spine - 2 views	$109.60
OST15	Lumbo-sacral spine 3 - 6 views	$151.20
OST16	Sacro-coccygeal area - 2 views	$91.30
OST27	Hip joint	$98.50
OST28	Pelvic girdle	$124.40

NON-SCHEDULED SERVICES

OS999	Non-scheduled services A service of a kind (other than a radiological service) not listed above, provided by an osteopath and authorised by a case manager or self-insured employer prior to the delivery of the service as being necessary, appropriate and reasonably required.	$166.20 per hour

Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

Note 2: Examples of activities and services that are not appropriate for reimbursement under item number OS999:

- electronic communications related to clinical consultations and other treatment services

- letters or reports that would normally be considered as part of a clinical consultation
- non-attendance or cancellation fees for treatment services
- photocopying.

SCHEDULE 5—SCALE OF CHARGES—PHYSIOTHERAPY SERVICES

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

Item	Description	Max Fee (excl GST)

INITIAL CONSULTATION

An initial consultation by a treating physiotherapist involving some or all of the following elements (although the extent of the consultation is at the discretion of the physiotherapist):

(a) Subjective reporting
Consideration by the physiotherapist of major symptoms and lifestyle factors (including impacts on activities of daily living), current history and treatment, past history and treatment, pain, 24 hour behaviour pattern, aggravating and relieving factors, general health, medication, risk factors, work history and current work duties.

(b) Objective assessment
Assessment by the physiotherapist of movement (eg, active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements etc) and the carrying out of appropriate procedures and tests.

(c) Assessment results
Provisional diagnosis, the setting of functional goals and the development of a management plan, in consultation with the injured worker, by the physiotherapist.

(d) Treatment
Discussion with the physiotherapist and the worker regarding diagnosis, treatment goals and expected outcomes, initial treatment and response and the provision of advice by the physiotherapist regarding bio-psychosocial issues, self management strategies, including any exercise programs that have been recommended.

(e) Clinical records
Recording of information by the physiotherapist in the worker's clinical records, including the results of procedures and tests carried out.

(f) Communication
Communication of relevant information by the physiotherapist may be to the certifying medical practitioner and other health practitioners, the employer, claims agent, legal representatives and the worker.

PT108	Initial consultation involving some or all of the elements of an initial consultation.	$74.80

SUBSEQUENT CONSULTATION

A subsequent consultation by a treating physiotherapist involving assessment and treatment of a worker's condition and some or all of the other elements listed below (although the extent of the consultation is at the discretion of the physiotherapist):

(a) History taking/assessment.
Consideration by the physiotherapist of the clinical records of the worker relating to their presenting condition and the worker's progress since the previous consultation.

(b) Examination
Examination by the physiotherapist of the condition.

(c) Treatment
Appropriate treatment of the condition, including the management of bio-psychosocial issues, by the physiotherapist.

(d) Reassessment and management

Reassessment of functional, return to work and treatment goals, the treatment plan, the worker's self-management strategies and overall physiotherapy management program.

(e) Communication
Communication of relevant information by the physiotherapist to the certifying medical practitioner should be made at or prior to medical review. Relevant information that supports appropriate injury management and remain at and return to work goals should also be communicated to other allied health practitioners, the employer, claims agent, legal representatives and the worker.

(f) Physiotherapy treatment form
If treatment is expected to extend for longer than 6 weeks, completion by the physiotherapist of a physiotherapy treatment form (in a form approved by WorkCover) and forwarding of the form to the claims agent or self-insured employer.
No additional fee is payable for completion of this form.

(g) Clinical records
Recording of information by the physiotherapist in the worker's clinical records, including the results of any procedures and tests carried out.

PT210	Standard subsequent consultation involving assessment and treatment and some or all of the elements of a subsequent consultation.	$60.90
PT212	Long subsequent consultation involving all of the elements of a subsequent consultation and because of the complexity of the injury will require extra time for history taking, examination, treatment, documenting and liaison. This type of consultation is expected in cases of injuries following extensive burns, major trauma and major surgery requiring intensive post-operative treatment. Where appropriate, validated tools will be used to measure and establish baseline functional capacity and progress in management will be recorded through the use of appropriate outcome measures. Management should include collaborative goal setting.	$83.20

CORRECTIVE/SERIAL SPLINTING

A splint is provided for correction and/or prevention of musculoskeletal imbalance. It may be prescribed to facilitate return to work or resumption of activities of daily living. A splint may be used as an adjunct to a treatment regime that includes corrective exercises/activities.

PT300	Fabrication/fitting/adjustment of splint.	$166.20 per hour

AQUATIC PHYSIOTHERAPY

PT415	Individual aquatic physiotherapy session. An aquatic physiotherapy session planned by a physiotherapist where an individual worker is constantly and directly supervised and assessed by the physiotherapist. The session will involve all or some of the elements of a subsequent consultation. (An initial or subsequent consultation cannot be charged on the same day as this service). Continued individual aquatic physiotherapy sessions may be justified in cases of severe trauma, fear of water, incompetence in water to recover safely from head-down immersion, or where the use of specific manual aquatic physiotherapy techniques can be justified both clinically and cost effectively (eg, Halliwick, Bad Ragaz, passive joint mobilisations and manual facilitation of preferred movement patterns).	$58.30 flat fee
PT420	Subsequent individual or group aquatic physiotherapy session. An aquatic physiotherapy session not referred to in PT415. (An initial or subsequent consultation cannot be charged on the same day as this service).	$24.30 per worker

Note 1: A review session at week four to six of the aquatic physiotherapy program should be undertaken. As a component of this review, consideration should be given to the appropriateness of progression to land based exercises.

Note 2: If the session is a group session:
- the group will be comprised of not more than six workers

- the session will involve programs that are unique and individualised to particular workers.

EXERCISE

PT455	Individual exercise session. Exercise session (other than an aquatic physiotherapy session) planned by a physiotherapist where an individual worker is constantly and directly supervised and assessed by the physiotherapist. The session will involve all or some of the elements of a subsequent consultation (An initial or subsequent consultation cannot be charged on the same day as this service). An exercise program should commence with an individual session and up to a maximum of four individual sessions may be required for the implementation of this worker's exercise program. The program should then progress into group exercise sessions.	$58.30 flat fee
PT460	Group exercise session. Group exercise session (other than an aquatic physiotherapy session) planned and supervised by a physiotherapist for a group of not more than eight workers. (An initial or subsequent consultation cannot be charged on the same day as this service).	$17.20 per worker

INDEPENDENT CLINICAL ASSESSMENT AND REPORT

PT780	Independent clinical assessment and report. Service provided by a physiotherapist other than the treating physiotherapist comprising: (a) a review of the worker's medical history (b) a clinical assessment (c) a review of the worker's activity and functional capacity (d) preparation of a report, for the purpose of providing a differential diagnosis and/or making recommendations in relation to ongoing treatment/management services, functional goals, the worker's capacity to return to work and any other relevant matters, and where appropriate, align future management with the guiding principles and expectations of the Clinical Framework.	$166.20 per hour

Note 1: An independent clinical assessment must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: This service cannot be performed by the treating physiotherapist. The independent clinical assessor must remain independent in relation to treatment services during and following an independent clinical assessment.

Note 3: An independent clinical assessment report must:
(i) provide recommendations for further treatment/management (including referrals to other agencies) and the expected benefit to the worker
(ii) address all questions asked by the referrer and where any question cannot be answered, provide an explanation
(iii) be limited to the relevant circumstances of the worker's injury/condition
(iv) be based on appropriate clinical examination, assessment and review of reports
(v) be consistent with accepted clinical practice and based on objective clinical findings
(vi) be accurate, unbiased, precise and consistent
(vii) document any inability to obtain the worker's consent to any aspect of the assessment.

Note 4: Payment will only be made following submission of the report.

Note 5: Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in

the case file.

Note 6: An independent clinical assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete an independent clinical assessment and report must be accumulated then rounded to the nearest 6 minutes.

TELEPHONE CALLS

PT552 Telephone call greater than 3 minutes. $23.10 flat fee

Note 1: Telephone calls are chargeable if they are of a case specific nature, made to or received from a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative
- WorkCover medical consultant
- workplace rehabilitation provider
- worker's referring/treating medical practitioner.

Note 2: Telephone calls are NOT chargeable if:
- made during a consultation
- made to or from a worker
- the call duration is 3 minutes or less.

Note 3: This communication should not replace expected communication methods and reports between treating or referring practitioners.

Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party.

Note 5: Telephone calls related to an independent clinical assessment (ICA) or medical expert rehabilitation services (MERS), are not chargeable under this item.

TREATING PHYSIOTHERAPY REPORTS

PT820 Standard report. $166.20 flat fee
A standard report is a clinical opinion, statement or response to questions relating to the status of the claim.

Note 1: A standard report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A standard report should be based on the physiotherapist's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example, if the physiotherapist has not seen the patient for some time) a consultation fee may be charged using item number PT815.

Note 3: Payment will only be made following submission of the report.

PT810 Comprehensive report. $166.20 per hour
A comprehensive report is a clinical opinion, statement or response to questions relating to the status of a claim and requires additional information above that required by a standard report due to the complexity of the case. Complexity is defined as:
- three or more ongoing compensable injuries arising from the same claim
- pre-existing conditions that have a significant impact on the compensable injury
- co-morbidities that have a significant impact on the compensable disability.

The maximum time chargeable for this item is 2 hours.

Note 1: A comprehensive report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A comprehensive report should be based on the physiotherapist's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example, if the physiotherapist has not seen the patient for some time), a consultation fee may be charged using item number PT815.

Note 3: Payment will only be made following submission of the report.

Note 4: Any part of an hour should be charged proportionately and rounded to the nearest six minutes.

CONSULTATION FOR PREPARING A TREATING PHYSIOTHERAPY REPORT

PT815	Consultation for the purposes of preparing a standard or comprehensive treating physiotherapy report.	$60.90 flat fee

CASE CONFERENCE

PT870	Case conference. Case conference attended by a physiotherapist for the purpose of discussing: - details of limitations/recommendations relating to a sustainable return to work - options for the management of a worker's recovery and functional restoration - barriers to return to work - other related information.	$166.20 per hour

Note 1: A case conference must be requested in writing by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative
- workplace rehabilitation provider
- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by a physiotherapist during the case conference unless delegated as the representative by the claims agent or self-insured employer. It is the responsibility of the claims agent, 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: Travel may be charged separately in accordance with item number PT905.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TRAVEL TIME

PT905	Travel time. Travel by a physiotherapist for the purpose of a: (a) a case conference (b) a home, hospital or worksite visit (c) consultation where the worker is otherwise unable to attend the physiotherapist's clinic or rooms.	$141.10 per hour

Note 1: There is no charge for travel from one clinic or rooms to another clinic or rooms.

Note 2: Physiotherapists who conduct regular sessional visits with particular hospitals, specialist practitioners or rehabilitation facilities may not charge for travel in these instances.

Note 3: Travel time is not included in any of the charges in the schedule and should be itemised separately on accounts for associated services.

Note 4: All accounts must include the total time spent travelling plus the distance travelled.

Note 5: Where a physiotherapist provides services to multiple workers in a hospital or workplace, it is expected the travel charge will be divided accordingly.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

MEDICAL EXPERT REHABILITATION SERVICES

ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT

PT760 Activities of daily living assessment and report. $166.20 per hour

Assessment by a physiotherapist, usually conducted in a worker's home environment, to assess the worker's level of functioning in relation to personal care, household tasks and recreational and social activities.

The purpose of the assessment is to reduce the potential adverse impact of the injury on the worker to facilitate early return to normal activity, and to provide an indicator of functional tolerances for determining work capacity.

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer. Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A visit is made to the home or hospital within five working days of receipt of written referral and/or approval by the treating medical practitioner, claims agent or self-insured employer or within a timeframe specified by the referrer.

Note 3: Reports written as a result of an activities of daily living assessment must be incorporated in the total charge for the service. They must not be charged using other physiotherapy report item codes.

Note 4: A final report is to be provided within 10 business days of completing the activities of daily living assessment.

Note 5: Any time spent on communication directly related to an activities of daily living assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete an activities of daily living and report must be accumulated then rounded to the nearest 6 minutes.

FUNCTIONAL CAPACITY EVALUATION AND REPORT

A functional capacity evaluation is undertaken to determine a worker's abilities over a range of physical demands in order to make recommendations for participation in work. The functional capacity evaluation is a standardised battery of tests used to evaluate a worker's capacity for work-related activities.

PT700 Functional capacity evaluation and report. $166.20 per hour

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer. Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A functional capacity evaluation should only be undertaken when the required information about capacity is not available through other means.

Note 3: The maximum time chargeable for this item is 7 hours. Invoices that exceed this amount will be returned for amendment.

Note 4: Report written as a result of a functional capacity evaluation must:
- include an executive summary outlining the major components of the service and relevant findings
- be incorporated in the total charge for the service. They must not be charged using other physiotherapy report item codes.

Note 5: A final report is to be provided within 10 business days of completing the functional capacity evaluation.

Note 6: Any time spent on communication directly related to a functional capacity evaluation and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 7: A functional capacity evaluation and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 8: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a functional capacity evaluation and report must be accumulated then rounded to the nearest 6 minutes.

GRADUATED RETURN TO WORK PROGRAM AND REPORT

The purpose of the program is to maximise the worker's ability to return to work. The program will be highly structured, goal orientated and individualised for each worker.

PT750 Graduated return to work program and report. $166.20 per hour
The program will involve actual and productive work duties identified by the physiotherapist as being within the worker's capacity and work practice guidelines relevant to the nature of the worker's injury and the performance of the particular duties.

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer. Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A medical clearance should be obtained prior to implementing the graduated return to work program.

Note 3: The program will not exceed 12 weeks unless an increase in capacity is demonstrated and the claims agent or self-insured employer approves an extension of the program.

Note 4: Reports written as a result of a graduated return to work program must be incorporated in the total charge for the service. They must not be charged using other physiotherapy report item codes.

Note 5: A final report is to be provided within 10 business days of completing the graduated return to work program.

Note 6: Any time spent on communication directly related to a graduated return to work program and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a graduated return to work program and report must be accumulated

then rounded to the nearest 6 minutes.

JOB ANALYSIS AND REPORT

PT740 Job analysis and report. $166.20
Attendance by a physiotherapist at a designated workplace to analyse available duties. per hour

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer. Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: A job analysis includes:
(a) an analysis of the critical physical demands of available duties
(b) determining the worker's capacity to undertake the duties and individual tasks giving consideration to available medical guidelines, the physiotherapist's knowledge of the worker's diagnosis, pathology and prognosis, and other factors relevant to the worker's participation in work-related activities
(c) making recommendations regarding:
(i) modifications of duties and/or individual tasks
(ii) the provision of equipment, therapeutic aids or appliances
(iii) introducing work practice guidelines to ensure the worker utilises safe body mechanics.
(d) preparation of a report with an executive summary outlining the major components of the service and relevant findings.

Note 3: Reports written as a result of a job analysis must be incorporated in the total charge for the service. They must not be charged using other physiotherapy report item codes.

Note 4: A final report is to be provided within 10 business days of completing the job analysis.

Note 5: Any time spent on communication directly related to a job analysis and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: A job analysis and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a job analysis and report must be accumulated then rounded to the nearest 6 minutes.

WORKSITE ASSESSMENT AND REPORT

PT730 Worksite assessment and report. $166.20
Attendance by a physiotherapist at a designated workplace in order to obtain an overview of the workplace, the worker's current duties and determine the availability of suitable duties. per hour

Note 1: Referrals must be requested in writing by a claims agent or self-insured employer. Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: The physiotherapist should visit the workplace within five business days of receipt of written referral or within a time specified by the referrer, subject to the employers cooperation.

Note 3: Reports written as a result of a worksite assessment must be incorporated in the total charge for the service. They must not be charged using other physiotherapy report item codes.

Note 4: A final report is to be provided within 10 business days of completing the worksite assessment.

Note 5: Any time spent on communication directly related to a worksite assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: A worksite assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 7: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a worksite assessment and report must be accumulated then rounded to the nearest 6 minutes.

NON-SCHEDULED SERVICES

PT999	Non-scheduled services. A service of a kind not listed above, provided by a physiotherapist and authorised by a claims agent or self-insured employer prior to the delivery of the service as being necessary, appropriate and reasonably required.	$166.20 per hour

Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

Note 2: Examples of activities and services that are not appropriate for reimbursement under item number PT999:

- electronic communications related to clinical consultations and other treatment services
- letters or reports that would normally be considered as part of a clinical, gymnasium or aquatic (hydrotherapy) consultation
- non-attendance or cancellation fees for treatment services
- functional capacity evaluation hire costs
- stand-alone massage or acupuncture
- assessments included as part of a consultation i.e. real-time ultrasound
- photocopying.

SCHEDULE 6—SCALE OF CHARGES—PSYCHOLOGY SERVICES

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

Item	Description	Max Fee (excl GST)
	CONSULTATIONS	
	Initial consultation. Treatment and intervention by a psychologist involving the psychologist's attendance with the worker. This includes face to face sessions, sessions conducted over the telephone, emergency telephone contact and video calling.	
PS101	An initial attendance of not more than 15 minutes duration.	$41.50
PS102	An initial attendance of more than 15 minutes duration but not more than 30 minutes duration.	$62.20
PS103	An initial attendance of more than 30 minutes duration but not more than 45 minutes duration.	$103.90
PS104	An initial attendance of more than 45 minutes duration but not more than 75 minutes duration.	$166.20
PS105	An initial attendance of more than 75 minutes duration but not more than 90 minutes duration.	$228.40

PS106	An initial attendance of greater than 90 minutes duration.	$249.30

Note 1: The maximum fee chargeable for an initial consultation is $249.30 (item number PS106). Multiple consultations (including initial and subsequent) cannot be charged on the same day.

Note 2: If treatment or intervention is provided at a location other than the psychologists professional rooms (for example the workplace), travel should be charged separately using the travel item number.

Subsequent consultation.
Treatment and intervention by a psychologist involving the psychologist's attendance with the worker. This includes face to face sessions, sessions conducted over the telephone, emergency telephone contact and video calling.

PS121	A subsequent attendance of not more than 15 minutes duration.	$41.50
PS122	A subsequent attendance of more than 15 minutes duration but not more than 30 minutes duration.	$62.20
PS123	A subsequent attendance of more than 30 minutes duration but not more than 45 minutes duration.	$103.90
PS124	A subsequent attendance of more than 45 minutes duration but not more than 75 minutes duration.	$166.20
PS125	A subsequent attendance of more than 75 minutes duration but not more than 90 minutes duration.	$228.40
PS126	A subsequent attendance of more than 90 minutes duration.	$249.30

Note 1: Subsequent consultations should be face to face with the worker. However, where subsequent consultations are undertaken over the telephone or via video calling, the psychologist should ensure that a face to face session is booked at regular intervals.

Note 2: The maximum fee chargeable for a subsequent consultation is $249.30 (item number PS126). Multiple consultations (including initial and subsequent) cannot be charged on the same day.

Note 3: If treatment or intervention is provided at a location other than the psychologists professional rooms (for example the workplace), travel should be charged separately using the travel item number.

PSYCHOLOGICAL ASSESSMENT

Psychological assessment.
A psychological assessment includes any clinical or psychometric assessment by a psychologist to assist the worker to manage the injury or consequences of the injury (this item includes assessment and interpretation of results).

PS111	A psychological attendance of not more than 15 minutes duration.	$41.50
PS112	A psychological attendance of more than 15 minutes duration but not more than 30 minutes duration.	$62.20
PS113	A psychological attendance of more than 30 minutes duration but not more than 45 minutes duration.	$103.90
PS114	A psychological attendance of more than 45 minutes duration but not more than 75 minutes duration.	$166.20
PS115	A psychological attendance of more than 75 minutes duration but not more than 105 minutes duration.	$249.30

PS116	A psychological attendance of more than 105 minutes duration but not more than 135 minutes duration.	$332.30
PS117	A psychological attendance of more than 135 minutes duration.	$376.70

Note 1: A psychological assessment may be used in addition to an initial or subsequent consultation and should be itemised separately. The purpose of an initial psychological assessment is to:
- clarify the diagnosis
- assist in treatment planning
- identify any issues relevant to treatment and intervention, and establish a baseline measure.

The purpose of a subsequent psychological assessment is to:
- assess treatment progress, and
- identify any issues relevant to current and/or future treatment and intervention.

Note 2: The maximum fee chargeable for a psychological assessment is $376.70 (item number PS117). Multiple psychological assessments cannot be charged on the same day.

GROUP THERAPY

Group therapy.
Attendance includes a group of workers or family members under the continuous direct supervision of a psychologist.

PS704	A group therapy attendance of more than 45 minutes duration but not more than 75 minutes duration.	$32.80 each client
PS705	A group therapy attendance of more than 75 minutes duration but not more than 105 minutes duration.	$50.40 each client
PS706	A group therapy attendance of more than 105 minutes duration but not more than 135 minutes duration.	$66.80 each client
PS707	A group therapy attendance of more than 135 minutes duration.	$74.40 each client

Note 1: 'Group' means attendance by a minimum of 2 persons and maximum of 9 persons.

Note 2: Multiple group therapy services cannot be charged on the same day for the same client.

FAMILY THERAPY

Family group therapy (two clients)

PS724	A family group therapy (2 clients) attendance of more than 45 minutes duration but not more than 75 minutes duration.	$83.10 each client
PS725	A family group therapy (2 clients) attendance of more than 75 minutes duration but not more than 105 minutes duration.	$124.70 each client
PS726	A family group therapy (2 clients) attendance of more than 105 minutes duration but not more than 135 minutes duration.	$166.20 each client
PS727	A family group therapy (2 clients) attendance of more than 135 minutes duration.	$187.50 each client

Note 1: Multiple family therapy services cannot be charged on the same day for the same client.

Family group therapy (three or more clients)

PS714	A family group therapy attendance of more than 45 minutes duration but not more then 75 minutes duration.	$55.40 each client
PS715	A family group therapy attendance of more than 75 minutes duration but not more than 105 minutes duration.	$83.10 each client
PS716	A family group therapy attendance of more than 105 minutes duration but not more than 135 minutes duration.	$110.80 each client
PS717	A family group therapy attendance of more than 135 minutes duration.	$124.70 each client

Note 1: Multiple family therapy services cannot be charged on the same day for the same client.

INTERVIEW OF ANOTHER PERSON OTHER THAN A WORKER

Interview of another person other than a worker.
Interview by a psychologist of a person other than a worker (eg, spouse, employer, supervisor, rehabilitation and return to work coordinator) for the purposes of obtaining information crucial to the treatment and management of the injury. The psychologist must be able to provide clear justification for this service, if requested.

PS131	Interview of a person other than a worker, not more than 15 minutes duration.	$41.50
PS132	Interview of a person other than a worker, more than 15 minutes duration but not more than 30 minutes duration.	$62.20
PS133	Interview of a person other than a worker, more than 30 minutes duration but not more than 45 minutes duration.	$103.90
PS134	Interview of a person other than a worker, more than 45 minutes duration but not more than 75 minutes duration.	$166.20
PS135	Interview of a person other than a worker, more than 75 minutes duration.	$207.70

Note 1: The maximum fee chargeable for this service is $207.70 (item number PS135). Multiple services cannot be charged on the same day.

Note 2: If the psychologist travels for the purpose of interviewing a person other than a worker, travel must be charged separately using the travel item number.

INDEPENDENT CLINICAL ASSESSMENT AND REPORT

PS780	Independent clinical assessment and report. Services provided by a psychologist other than the treating psychologist comprising: a) a review of the worker's psychological/medical history including psychosocial treatment and functional status b) a clinical assessment c) a review of the worker's activity and functional capacity d) preparation of a report, for the purpose of providing a differential diagnosis and/or making recommendations in relation to ongoing treatment/management services, functional goals, the worker's capacity to return to work and any other relevant matters, and where appropriate, align future management with the guiding principles and expectations of the Clinical Framework.	$166.20 per hour

Note 1: An independent clinical assessment must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.
Treating medical experts may ask one of the above to request this service if deemed necessary.

Note 2: This service cannot be performed by the treating psychologist. The independent clinical assessor must remain independent in relation to treatment services during and following an independent clinical assessment.

Note 3: An independent clinical assessment report must:
(i) provide recommendations for further treatment/management (including referrals to other agencies) and the expected benefit to the worker
(ii) address all questions asked by the referrer and where any question cannot be answered, provide an explanation
(iii) be limited to the relevant circumstances of the worker's injury/condition
(iv) be based on appropriate clinical examination, assessment and review of reports
(v) be consistent with accepted clinical practice and based on objective clinical findings
(vi) be accurate, unbiased, precise and consistent
(vii) document any inability to obtain the worker's consent to any aspect of the assessment.

Note 4: Payment will only be made following submission of the report.

Note 5: Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 6: An independent clinical assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 7: All component activites (e.g. telephone calls, assessment, report etc.) undertaken to complete an independent clinical assessment and report must be accumulated then rounded to the nearest six minutes.

VOCATIONAL ASSESSMENT AND REPORT

PS315 Vocational assessment and report. $166.20 per hour

A vocational assessment of a worker by a psychologist to identify potential and alternative career employment options carried out by means of integrated clinical and standardised assessment procedures and instruments.
A vocational report by a psychologist providing advice on factors affecting occupational options following a vocational assessment. These factors may include:
(a) psychosocial factors such as beliefs, motivation, attitude and personality
(b) skills and abilities
(c) cultural, religious or ethnic factors
(d) socio economic context
(e) medical status
(f) education
(g) advice on strategies to assist in the return to work process.

Note 1: A vocational assessment must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: The maximum time chargeable for this item is seven hours. Invoices that exceed this amount will be returned for amendment.

Note 3: Payment will only be made following submission of the report.

Note 4: Any time spent on communication directly related to a vocational assessment and report is included within the total time invoiced for this service. The other party and duration of the communication activity must be recorded in the case file.

Note 5: A vocational assessment and report must be invoiced as a single transaction for the total time accumulated in providing this service.

Note 6: All component activities (e.g. telephone calls, assessment, report etc.) undertaken to complete a voctional assessment and report must be accumulated then rounded to the nearest six minutes.

TELEPHONE CALLS

PS552 Telephone call. $166.20 per hour

Note 1: Telephone calls are chargeable if they are of a case specific nature, made to or receive from the:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative
- WorkCover medical consultant
- workplace rehabilitation provider
- worker's referring/treating medical practitioner.

Note 2: Telephone calls are NOT chargeable if:
- made during a consultation
- made to or from a worker.

Note 3: This communication should not replace expected communication methods and reports between treating or referring practitioners.

Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party.

Note 5: Telephone calls related to an independent clinical assessment (ICA) or vocational assessment (VA), are not chargeable under this item.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TREATING PSYCHOLOGY REPORTS

PS820 Standard report. $166.20 flat fee

Request for a progress report, where history and other details are already held on file covering a small number of specific questions. Questions may cover areas such as:
- the current psychological status of the worker
- a summary of the current treatment/treatment approach
- anticipated future treatment required, or
- similar specific questions relevant to managing the case.

Note 1: A standard report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: The maximum time chargeable for this item is one hour.

Note 3: A standard report should be based on the psychologist's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example if the psychologist has not seen the patient for some time) a consultation fee may be charged using item number PS815.

Note 4: Payment will only be made following submission of the report.

PS810 Comprehensive report. $166.20 per hour

A comprehensive report is a clinical opinion, statement or response to questions relating to the status of the claim and requires additional information above that required by a standard report due to the complexity of the case.

Complexity is defined as:
- three or more ongoing compensable injuries arising from the same claim
- pre-existing conditions that have a significant impact on the compensable injury
- co-morbidities that have a significant impact on the compensable disability.

Note 1: A comprehensive report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: The maximum time chargeable for this item is four hours.

Note 3: A comprehensive report should be based on the psychologist's notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example if the psychologist has not seen the patient for some time) a consultation fee may be charged using item number PS815.

Note 4: Payment will only be made following submission of the report.

Note 5: Any part of an hour should be charged proportionately and rounded to the nearest six minutes.

CONSULTATION FOR PREPARING A TREATING PSYCHOLOGY REPORT

PS815	Consultation for the purposes of preparing a treating psychology report.	$166.20 flat fee

CASE CONFERENCE

PS870	Case conference. Case conference attended by a psychologist for the purpose of discussing: - details of limitations/recommendations relating to a sustainable return to work - options for the management of a worker's recovery and functional restoration - information relating to suitable duties at the workplace - barriers to return to work - other related information.	$166.20 per hour

Note 1: A case conference must be requested in writing by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative
- workplace rehabilitation provider
- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by a psychologist during the case conference unless delegated as the representative by the claims agent or self-insured employer. It is the responsibility of the claims agent, 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: Travel may be charged separately in accordance with item number PS905.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TRAVEL TIME

PS905	Travel time. Travel by a psychologist for the purpose of a: (a) case conference (b) home, hospital or worksite visit (c) consultation where the worker is otherwise unable to attend the psychologist's clinic or rooms.	$166.20 per hour

Note 1: There is no charge for travel from one clinic or rooms to another clinic or rooms.

Note 2: Psychologists who conduct regular sessional visits with particular hospitals, specialist practitioners or rehabilitation facilities may not charge for travel in these instances.

Note 3: Travel time is not included in any of the charges in the schedule and should be itemised separately on accounts for associated services.

Note 4: All accounts must include the total time spent travelling plus the distance travelled.

Note 5: Where a psychologist provides services to multiple workers in a hospital or workplace, it is expected the travel charge will be divided accordingly.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

NON-SCHEDULED SERVICES

PS999	Non-scheduled services. A service of a kind not listed above provided by a psychologist and authorised by a claims agent or self-insured employer prior to the delivery of the service as being necessary, appropriate and reasonably required.	$166.20 per hour

Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

Note 2: Examples of activities and services that are not appropriate for reimbursement under item number PS999:
- electronic communications related to clinical consultations and other treatment services
- letters or reports that would normally be considered as part of a clinical consultation
- non-attendance or cancellation fees for treatment services
- photocopying.

SCHEDULE 7—SCALE OF CHARGES—SPEECH PATHOLOGY SERVICES

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

Item	Description	Max Fee (excl GST)

INITIAL CONSULTATION

Consultation by a speech pathologist involving the speech pathologist's attendance with the worker.

E0149	Standard initial consultation. The maximum time chargeable for this item is 1.5 hours.	$166.20 per hour

E0151	Extended initial consultation greater than 1.5 hours duration. The maximum time chargeable for this item is 2.5 hours.	$166.20 per hour

Note 1: An initial consultation by a speech pathologist involving some or all of the following elements:
- the taking of a detailed case history
- counselling (according to the worker's emotional needs)
- determination of options for ongoing management following assessment
- consideration and implementation of appropriate treatment
- administration of a standardised clinical assessment or an empirical clinical assessment
- assessment of the ability of the worker to communicate at the worker's workplace
- evaluation and analysis of assessment results.

The initial consultation will be designed to form the basis of the diagnosis and assist in prognostic indications and treatment planning.

Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

SUBSEQUENT CONSULTATION

E0249	Subsequent consultation. The maximum time chargeable for this item is 1 hour.	$166.20 per hour

Note 1: A subsequent consultation by a speech pathologist involving treatment and intervention designed to restore the worker's function to optimal levels. The consultation may involve:
- tasks specifically related to skill development
- counselling to facilitate adjustment and transfer of restored skills to everyday communicative situations.

Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TELEPHONE CALLS

E0552	Telephone call.	$166.20 per hour

Note 1: Telephone calls are chargeable if they are of a case specific nature, made to or received from the:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker's representative
- WorkCover medical consultant
- workplace rehabilitation provider
- worker's referring/treating medical practitioner.

Note 2: Telephone calls are NOT chargeable if:
- made during a consultation
- made to or from a worker.

Note 3: This communication should not replace expected communication methods and reports between treating or referring practitioners.

Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TREATING SPEECH PATHOLOGY REPORTS

E0820 Standard report. $249.50
A standard report is a clinical opinion, statement or response to questions relating to the status of a claim. flat fee

Note 1: A standard report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A standard report should be based on the speech pathologists notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example if the speech pathologist has not seen the patient for some time) a consultation fee may be charged using item number E0815.

Note 3: Payment will only be made following submission of the report.

E0810 Comprehensive report. $166.20
A comprehensive report is a clinical opinion, statement or response to questions relating to the status of the claim and requires additional information above that required by a standard report due to the complexity of the case. Complexity is defined as: per hour
- three of more ongoing compensable injuries arising from the same claim
- pre-existing conditions that have a significant impact on the compensable injury
- co-morbidities that have a significant impact on the compensable disability.

The maximum time chargeable for this item is 4 hours.

Note 1: A comprehensive report must be requested in writing by a:
- claims agent or self-insured employer
- worker or worker's representative.

Note 2: A comprehensive report should be based on the speech pathologists notes and would not usually require a consultation with the patient. However, where a consultation is appropriate (for example if the speech pathologist has not seen the patient for some time) a consultation fee may be charged using item number E0815.

Note 3: Payment will only be made following submission of the report.

Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

CONSULTATION FOR PREPARING A TREATING SPEECH PATHOLOGY REPORT

E0815 Consultation for the purposes of preparing a standard or comprehensive treating speech pathology report. $166.20 flat fee

CASE CONFERENCE

E0870 Case conference. $166.20
Case conference, attended by a speech pathologist for the purpose of discussing: per hour
- details of limitations/recommendations relating to a sustainable return to work
- options for the management of a worker's recovery and functional restoration
- information relating to suitable duties at the workplace
- barriers to return to work
- other related information.

Note 1: A case conference must be requested in writing by a:
- claims agent or self-insured employer
- worker's employer (including the employer's rehabilitation and return to work co-ordinator)
- worker or worker's representative
- workplace rehabilitation provider

- treating medical expert.

Note 2: The claims agent or self-insured employer should attend the case conference if at all possible. If the claims agent or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by a speech pathologist during the case conference unless delegated as the representative by the claims agent or self-insured employer. It is the responsibility of the claims agent, 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: Travel may be charged separately in accordance with item number E0905.

Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TRAVEL TIME

E0905	Travel time. Travel by a speech pathologist for the purpose of: (a) case conference (b) home, hospital or worksite visit (c) consultation where the worker is otherwise unable to attend the speech pathologist's clinic or rooms.	$141.10 per hour

Note 1: There is no charge for travel from one clinic or rooms to another clinic or rooms.

Note 2: Speech pathologists who conduct regular sessional visits with particular hospitals, specialist practitioners or rehabilitation facilities may not charge for travel in these instances.

Note 3: Travel time is not included in any of the charges in the schedule and should be itemised separately on accounts for associated services.

Note 4: All accounts must include the total time spent travelling plus the distance travelled.

Note 5: Where a speech pathologist provides services to multiple workers in a hospital or workplace, it is expected the travel charge will be divided accordingly.

Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

NON-SCHEDULED SERVICES

E0999	Non-scheduled services. A service of a kind not listed above, provided by a speech pathologist and authorised by a claims agent or self-insured employer prior to the delivery of the service as being necessary, appropriate and reasonably required.	$166.20 per hour

Note 1: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

Note 2: Examples of activities and services that are not appropriate for reimbursement under item number E0999:
- electronic communications related to clinical consultations and other treatment services
- letters or reports that would normally be considered as part of a clinical consultation

- non-attendance or cancellation fees for treatment services
- photocopying.

SCHEDULE 8—SCALE OF CHARGES—PRIVATE HOSPITAL AND DAY SURGERY FACILITIES

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

Item	Description	Max Fee (excl GST)

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 in 1999 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 4.2, Addendum to Definitions Manual, Volume 4,*, produced in 2000 by the Commonwealth Department of Health and Aged Care (read with the *Australian Refined Diagnosis Related Groups, Version 4.1, Definitions Manual, Volumes 1-3*, produced in 1998 by the Commonwealth Department of Health and Aged Care).

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——

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

(c) 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, WorkCover will not be responsible for or accept any additional fee or surcharge.

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.

Item No.	Service description	Max fee – excl GST
PR600	Length of stay 1 or more days but not more than 16 days	$642.20 per day
PR605	17 or more days	$538.50 per day

Rehabilitation trauma program for inpatients

Trauma programs involve referral and assessment by the rehabilitation coordinator of the program. It is a defined program with intense service provision. Rapid improvement is expected and there are specific outcome goals. The program includes physiotherapy, aquatic therapy, occupational therapy, speech therapy, case conferences and discharge planning.

Item No.	Service description	Max fee – excl GST
PR610	Length of stay 1 or more days but not more than 20 days	$765.80 per day
PR615	21 or more days	$691.40 per day

PSYCHIATRIC SERVICES

Inpatient services

Item No.	Service description	Max fee – excl GST
PR800	Length of stay 1 or more days but not more than 14 days	$616.20 per day
PR803	15 or more days	$474.10 per day
PR822	Electro-convulsive therapy (ECT)	$263.80 per day
PR850	Private room allocated on the basis of clinical need	Extra $15.40 per day (additional charge)

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.

Item No.	Service description	Max fee – excl GST
PR990	Length of stay 1 or more days but not more than 10 days	$698.50 per day
PR991	11 or more days	$511.20 per day

Same day psychiatric services

A day program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients. It is managed by a multi-disciplinary team of health care professionals, and is tailored to the individual needs of the patient. It can include specialised therapy modules including cognitive behavioural therapy, relaxation, assertiveness skills and anxiety management.

Outreach is treatment or care provided by the hospital to a non-admitted patient at a location outside the hospital premises (being treatment or care provided as a direct substitute for treatment or care that would normally be provided on the hospital premises).

Item No.	Service description	Max fee – excl GST
PRO81	Group session	$84.10
PRO82	ECT day program	$437.90
PRO83	Half-day program	$224.20
PRO84	Day program	$354.90
PRO95	Outreach	$202.60

Please note, for billing purposes, the 'O' in item numbers for same day services is an alphabetical letter not the number zero.

OTHER SERVICES

Inpatient pain assessment/management

Item No.	Service description	Max fee – excl GST
PR700	Length of stay 1 or more days but not more than 7 days	$563.50 per day
PR705	8 or more days but not more than 14 days	$529.50 per day
PR710	15 or more days	$344.10 per day

Pain pumps for non- admitted patients

Item No.	Service description	Max fee – excl GST
PR720	Implanted infusion pump, refilling of reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain for a non-admitted patient.	$195.60

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, WorkCover will not be responsible, or accept any additional fee or surcharge.

INPATIENT SERVICES – DIAGNOSTIC RELATED GROUPS VERSION 4.2

Item No	Description	Max fee (ex GST)	Upper trim point days	Lower trim point days	Max per day rate (ex GST)
A06Z	Tracheostomy any age any cond	$59,970.00	35	11	$1,100.00
B01Z	Ventricular shunt revision	$4,969.00	12	2	$805.00
B02A	Craniotomy + ccc	$22,813.00	35	6	$1,059.00
B02B	Craniotomy + smcc	$13,782.00	20	3	$1,100.00
B02C	Craniotomy - cc	$11,115.00	14	2	$1,100.00
B03A	Spinal procedures + cscc	$11,216.00	20	3	$980.00
B03B	Spinal procedures - cscc	$6,000.00	7	1	$1,100.00
B04A	Extracranial vascular pr +cscc	$10,713.00	16	3	$1,100.00
B04B	Extracranial vascular pr -cscc	$6,377.00	8	1	$1,100.00
B05Z	Carpal tunnel release	$1,149.00	4	0	$743.00
B06A	Cbl psy,mus dysy,npthy pr+cscc	$8,050.00	24	4	$616.00
B06B	Cbl psy,mus dysy,npthy pr-cscc	$1,645.00	4	0	$898.00
B07A	Prphl & cranl nerv & oth pr+cc	$8,275.00	30	5	$526.00
B07B	Prphl & cranl nerv & oth pr-cc	$2,054.00	4	0	$900.00
B40Z	Plasmapheresis + neurolgcl dis	$982.00	5	0	$436.00
B60A	N-acute para/quad+/-or pr+ccc	$21,251.00	35	11	$633.00
B60B	N-acute para/quad+/-or pr-ccc	$3,413.00	11	2	$616.00
B61A	Spinal cord cond+/-or pr +cscc	$16,163.00	35	7	$683.00
B61B	Spinal cord cond+/-or pr -cscc	$7,010.00	12	2	$1,033.00
B62Z	Admit for apheresis	$376.00	4	0	$348.00
B63Z	Dmntia & chrnic disturb crbrl fn	$4,198.00	16	3	$555.00
B64Z	Delirium	$5,705.00	20	3	$591.00
B65Z	Cerebral palsy	$2,216.00	11	2	$415.00
B66A	Nervous system neoplasm a>64	$7,405.00	27	4	$567.00
B66B	Nervous system neoplasm a<65	$5,066.00	17	3	$604.00
B67A	Degnrtv nervous sys dsrd +cscc	$8,520.00	32	5	$544.00
B67B	Degnrtv nervous sys dsrd -cscc	$2,233.00	8	1	$590.00
B68A	Mlt sclrosis & cerebel ataxia+cc	$5,503.00	19	3	$582.00
B68B	Mlt sclrosis & cerebel ataxia-cc	$655.00	4	0	$502.00
B69A	Tia & precerebral occlusn+ccc	$6,446.00	24	4	$557.00
B69B	Tia & precerebral occlusn+scc	$4,326.00	15	2	$596.00
B69C	Tia & precerebral occlusn-cscc	$2,120.00	7	1	$627.00

B70A	Stroke +severe/compl dx/proc	$9,875.00	31	5	$638.00
B70B	Stroke + other cc	$5,930.00	18	3	$665.00
B70C	Stroke - other cc	$3,485.00	9	1	$760.00
B70D	Stroke died/transferred<5 days	$1,672.00	5	0	$767.00
B71A	Cranial & periphl nerv dsrd+cc	$4,856.00	17	3	$581.00
B71B	Cranial & periphl nerv dsrd-cc	$1,108.00	4	0	$547.00
B72Z	Nrvs sys inf ex vrl meningitis	$4,590.00	17	3	$557.00
B73Z	Viral meningitis	$2,039.00	9	1	$497.00
B74Z	Nontraumatic stupor & coma	$2,324.00	8	1	$605.00
B75Z	Febrile convulsions	$401.00	4	0	$291.00
B76A	Seizure a<3 + cscc	$3,158.00	13	2	$499.00
B76B	Seizure a>2 - cscc	$1,663.00	7	1	$507.00
B77Z	Headache	$1,664.00	7	1	$530.00
B78Z	Intracranial injury	$6,268.00	20	3	$652.00
B79Z	Skull fractures	$1,783.00	9	1	$424.00
B80Z	Other head injury	$929.00	5	0	$409.00
B81A	Other dsrd of nervous sys+cscc	$6,340.00	23	4	$570.00
B81B	Other dsrd of nervous sys-cscc	$2,693.00	10	2	$573.00
C01Z	Proc for penetratng eye injury	$1,223.00	4	0	$429.00
C02Z	Enucleations & orbital procs	$2,486.00	4	0	$1,090.00
C03Z	Retinal procedures	$1,427.00	4	0	$1,081.00
C04Z	Major corn, scleral & conjnct pr	$911.00	4	0	$585.00
C05Z	Dacryocystorhinostomy	$1,960.00	4	0	$976.00
C06Z	Complex glaucoma procedures	$2,076.00	4	0	$995.00
C07Z	Other glaucoma procedures	$1,420.00	4	0	$721.00
C08Z	Major lens procedures	$1,368.00	4	0	$922.00
C09Z	Other lens procedures	$1,199.00	4	0	$825.00
C10Z	Strabismus procedures	$1,149.00	4	0	$622.00
C11Z	Eyelid procedures	$1,449.00	4	0	$773.00
C12Z	Other corn, scleral & conjnct pr	$1,031.00	4	0	$618.00
C13Z	Lacrimal procedures	$732.00	4	0	$390.00
C14Z	Other eye procedures	$969.00	4	0	$530.00
C60A	Acute & mjr eye infectns a>54	$5,961.00	20	3	$615.00
C60B	Acute & mjr eye infectns a<55	$1,992.00	8	1	$511.00
C61Z	Neurological & vasclr eye dsrd	$1,707.00	7	1	$543.00
C62Z	Hyphema & med managd eye trauma	$1,831.00	8	1	$484.00
C63A	Other disorders of the eye +cc	$2,686.00	10	2	$561.00
C63B	Other disorders of the eye -cc	$815.00	4	0	$397.00
D01Z	Cochlear implant	$3,538.00	4	0	$1,100.00

D02A	Head & neck procedures + cc	$8,860.00	12	2	$1,100.00
D02B	Head & neck procedures - cc	$2,709.00	4	0	$1,100.00
D03Z	Surgcl rpr cleft lip/palate dx	$2,131.00	4	0	$855.00
D04A	Maxillo surgery + cc	$5,399.00	7	1	$1,100.00
D04B	Maxillo surgery - cc	$2,929.00	4	0	$1,100.00
D05Z	Sialoadenectomy	$3,431.00	4	0	$1,100.00
D06Z	Sinus, mastd & cmplx mddl ear pr	$2,446.00	4	0	$1,100.00
D07Z	Salivry gland pr-sialoadenctmy	$1,554.00	4	0	$763.00
D08Z	Mouth procedures	$1,168.00	4	0	$766.00
D09Z	Misc ear,nose,mouth & throat pr	$1,747.00	4	0	$1,076.00
D10Z	Rhinoplasty (+/-turbinectomy)	$2,101.00	4	0	$1,100.00
D11Z	Tonsillectomy, adenoidectomy	$1,350.00	4	0	$995.00
D12Z	Oth ear,nose,mouth & throat pr	$1,707.00	4	0	$912.00
D13Z	Myringotomy +tube insertion	$884.00	4	0	$583.00
D40Z	Dental extract & restorations	$858.00	4	0	$712.00
D60A	Ear nose mouth & throat mal+cscc	$8,394.00	30	5	$567.00
D60B	Ear nose mouth & throat mal-cscc	$2,460.00	8	1	$621.00
D61Z	Dysequilibrium	$2,216.00	8	1	$596.00
D62Z	Epistaxis	$1,287.00	5	0	$549.00
D63A	Otitis media & uri + cc	$2,952.00	11	2	$551.00
D63B	Otitis media & uri - cc	$1,147.00	5	0	$519.00
D64Z	Laryngotracheitis & epiglottitis	$366.00	4	0	$273.00
D65Z	Nasal trauma & deformity	$987.00	4	0	$521.00
D66A	Oth ear,nose,mouth & thrt dx +cc	$2,336.00	8	1	$555.00
D66B	Oth ear,nose,mouth & thrt dx -cc	$819.00	4	0	$548.00
D67Z	Dntal & oral dis-extrct & restrtns	$935.00	4	0	$493.00
E01A	Major chest procedure + ccc	$16,223.00	30	5	$1,039.00
E01B	Major chest procedure - ccc	$9,191.00	15	2	$1,100.00
E02A	Other respiratry sys or pr+ccc	$10,127.00	29	5	$681.00
E02B	Other respiratry sys or pr+scc	$3,563.00	10	2	$686.00
E02C	Other respiraty sys or pr-cscc	$1,839.00	4	0	$1,056.00
E40Z	Resp sys dx + ventilator suppt	$12,550.00	22	4	$1,100.00
E60A	Cystic fibrosis +cscc	$1,051.00	22	4	$96.00
E60B	Cystic fibrosis -cscc	$3,539.00	17	3	$435.00
E61A	Pulmonary embolism + cscc	$5,985.00	20	3	$622.00
E61B	Pulmonary embolism - cscc	$3,638.00	12	2	$625.00
E62A	Respiratry infectn/inflamm+ccc	$8,559.00	26	4	$662.00
E62B	Respiratry infectn/inflam+smcc	$4,997.00	16	3	$638.00
E62C	Respiratory infectn/inflamm-cc	$2,943.00	10	2	$634.00

E63Z	Sleep apnoea	$560.00	4	0	$521.00
E64Z	Pulmonry oedema & resp failure	$6,511.00	17	3	$750.00
E65A	Chrnic obstrct airway dis+cscc	$6,479.00	22	4	$606.00
E65B	Chrnic obstrct airway dis-cscc	$4,108.00	14	2	$613.00
E66A	Major chest trauma a >69 + cc	$7,599.00	26	4	$592.00
E66B	Mjr chest trma a<70+cc/a>69-cc	$4,347.00	13	2	$674.00
E66C	Major chest trauma a<70 - cc	$2,127.00	8	1	$599.00
E67A	Respiratry signs & symptm+cscc	$4,015.00	14	2	$598.00
E67B	Respirtry signs & sym a<3-cscc	$386.00	4	0	$297.00
E67C	Respirtry signs & sym a>2-cscc	$1,926.00	5	0	$730.00
E68Z	Pneumothorax	$2,646.00	10	2	$561.00
E69A	Bronchitis & asthma a>49 + cc	$4,757.00	16	3	$593.00
E69B	Brnchts & asthma a<50+cc/a>49-cc	$2,778.00	10	2	$584.00
E69C	Bronchitis & asthma a<50 - cc	$833.00	4	0	$458.00
E70A	Whoopng cgh & acte brnchio+cscc	$1,892.00	12	2	$330.00
E70B	Whoopng cgh & acte brnchio-cscc	$967.00	6	0	$382.00
E71A	Respiratory neoplasms + cc	$4,895.00	17	3	$579.00
E71B	Respiratory neoplasms - cc	$2,243.00	7	1	$629.00
E73A	Pleural effusion + ccc	$6,758.00	24	4	$565.00
E73B	Pleural effusn + scc	$3,852.00	13	2	$582.00
E73C	Pleural effusion - cscc	$2,174.00	8	1	$592.00
E74A	Interstial lung dis a>64 +cscc	$7,863.00	24	4	$650.00
E74B	Intrsl lng a<65+cscc/a>64-cscc	$3,777.00	14	2	$560.00
E74C	Interstial lung dis a<65 -cscc	$1,898.00	8	1	$507.00
E75A	Other resp sys dx a>64+cc	$5,257.00	18	3	$603.00
E75B	Ot resp sys dx a<65+cc/a>65-cc	$3,232.00	11	2	$620.00
E75C	Other resp sys dx a<65 - cc	$1,310.00	5	0	$548.00
F03Z	Crdc valv pr+pump+inva inve pr	$28,389.00	35	6	$1,100.00
F04A	Crd vlv pr+pmp-in inve pr+cscc	$23,878.00	25	4	$1,100.00
F04B	Crd vlv pr+pmp-in inve pr-cscc	$20,129.00	18	3	$1,100.00
F05A	Corony bypass+inva inve pr+ccc	$29,336.00	33	5	$1,100.00
F05B	Corony bypass+inva inve pr-ccc	$23,563.00	24	4	$1,100.00
F06A	Corony bypas-inva inve pr+cscc	$22,421.00	23	4	$1,100.00
F06B	Corony bypas-inva inve pr-cscc	$18,744.00	18	3	$1,100.00
F07Z	Other cardthorac/vasc pr+pump	$19,721.00	23	4	$1,100.00
F08A	Mjr reconstrc vasc pr-pump+ccc	$21,225.00	35	6	$1,069.00
F08B	Mjr reconstrc vasc pr-pump-ccc	$10,470.00	13	2	$1,100.00
F09Z	Other cardiothoracic pr-pump	$11,050.00	13	2	$1,100.00
F11A	Amputn circ sys-up lmb & toe+ccc	$23,093.00	35	11	$673.00

F11B	Amputn circ sys-up lmb & toe-ccc	$11,942.00	34	6	$647.00
F12Z	Cardiac pacemaker implantation	$5,315.00	8	1	$1,100.00
F13Z	Up limb & toe amptn crc sys dsrd	$8,321.00	23	4	$651.00
F14A	Vasc pr-mjr reconstrc-pump+ccc	$14,381.00	28	5	$854.00
F14B	Vasc pr-mjr reconstrc-pump+scc	$6,270.00	9	1	$1,059.00
F14C	Vasc pr-mjr reconstr-pump-cscc	$4,401.00	4	0	$1,100.00
F17Z	Cardiac pacemaker replacement	$2,773.00	4	0	$1,100.00
F18Z	Crdc pcmkr revsn -dvc rplcmnt	$5,576.00	8	1	$1,100.00
F19Z	Oth trns-vsclr perc crdc intrv	$8,099.00	8	1	$1,100.00
F20Z	Vein ligation & stripping	$2,505.00	4	0	$1,100.00
F21A	Ot circ sys or pr+ccc/a>64-ccc	$9,099.00	25	4	$673.00
F21B	Oth circul sys or pr a<65-ccc	$2,991.00	6	0	$798.00
F40Z	Circ sys dx+ventilator support	$16,366.00	21	3	$1,100.00
F41A	Crc dsrd+ami+inva inve pr+cscc	$8,098.00	14	2	$1,019.00
F41B	Crc dsrd+ami+inva inve pr-cscc	$5,089.00	6	0	$1,100.00
F42A	Crc dsrd-ami+ic in pr+cmpdx/pr	$4,570.00	6	1	$1,100.00
F42B	Crc dsrd-ami+ic in pr-cmpdx/pr	$3,222.00	4	0	$1,100.00
F60A	Crc dsrd+ami-inva inve pr+cscc	$7,287.00	20	3	$729.00
F60B	Crc dsrd+ami-inva inve pr-cscc	$3,504.00	9	1	$812.00
F60C	Crc dsrd+ami-inva inve pr died	$5,407.00	14	2	$807.00
F61Z	Infective endocarditis	$9,121.00	34	6	$524.00
F62A	Heart failure & shock + ccc	$8,899.00	28	5	$650.00
F62B	Heart failure & shock - ccc	$4,926.00	15	2	$668.00
F63A	Venous thrombosis + cscc	$5,564.00	20	3	$561.00
F63B	Venous thrombosis - cscc	$2,944.00	10	2	$590.00
F64Z	Skin ulcers circulatory disord	$8,247.00	28	5	$588.00
F65A	Peripheral vascular dsrd +cscc	$6,849.00	23	4	$610.00
F65B	Peripheral vascular dsrd -cscc	$1,412.00	5	0	$620.00
F66A	Coronary atherosclerosis + cc	$4,257.00	13	2	$656.00
F66B	Coronary atherosclerosis - cc	$1,693.00	5	0	$727.00
F67A	Hypertension + cc	$4,000.00	14	2	$591.00
F67B	Hypertension - cc	$2,409.00	8	1	$615.00
F68Z	Congenital heart disease	$646.00	4	0	$453.00
F69A	Valvular disorders + cscc	$5,203.00	18	3	$591.00
F69B	Valvular disorders - cscc	$1,311.00	4	0	$667.00
F70A	Mjr arrhythmia & crdc arrst+cscc	$6,272.00	17	3	$740.00
F70B	Mjr arrhythmia & crdc arrst-cscc	$2,410.00	6	0	$902.00
F71A	N-mjr arythm & condctn dsrd+cscc	$5,354.00	16	3	$698.00
F71B	N-mjr arythm & condctn dsrd-cscc	$1,464.00	5	0	$682.00

F72A	Unstable angina + cscc	$5,272.00	15	2	$729.00
F72B	Unstable angina - cscc	$2,435.00	6	0	$897.00
F73A	Syncope & collapse + cscc	$5,404.00	18	3	$604.00
F73B	Syncope & collapse - cscc	$2,235.00	7	1	$649.00
F74Z	Chest pain	$1,320.00	4	0	$704.00
F75A	Other circulatry system dx+ccc	$9,080.00	26	4	$701.00
F75B	Other circulatry system dx+scc	$4,156.00	13	2	$645.00
F75C	Other circulaty system dx-cscc	$2,109.00	6	0	$684.00
G01A	Rectal resection + ccc	$17,599.00	32	5	$1,031.00
G01B	Rectal resection - ccc	$10,671.00	17	3	$1,100.00
G02A	Mjr small & large bowel pr+ccc	$17,120.00	34	6	$952.00
G02B	Mjr small & large bowel pr-ccc	$7,521.00	14	2	$1,048.00
G03A	Stomch,oeshpgl & duodnl pr+mal	$18,661.00	29	5	$1,100.00
G03B	Stmch,oeshpgl & ddnl pr-mal+cscc	$11,633.00	19	3	$1,100.00
G03C	Stmch,oeshpgl & ddnl pr-mal-cscc	$4,841.00	5	0	$1,100.00
G04A	Peritoneal adhesolysis a>49+cc	$11,758.00	23	4	$972.00
G04B	Prtnl adhly(a<50+cc)/(a>49-cc)	$5,247.00	8	1	$1,100.00
G04C	Peritoneal adhesolysis a<50-cc	$3,716.00	6	0	$1,100.00
G05A	Mnr small & large bowel pr+cc	$5,182.00	14	2	$681.00
G05B	Mnr small & large bowel pr-cc	$1,910.00	4	0	$854.00
G07A	Appendicectomy + cscc	$5,216.00	10	2	$1,027.00
G07B	Appendicectomy - cscc	$2,878.00	5	0	$1,066.00
G08Z	Abdom, umb & oth hernia pr a>0	$2,563.00	4	0	$1,100.00
G09Z	Inguinal & femoral hernia pr a>0	$2,173.00	4	0	$1,100.00
G10Z	Hernia procedures a<1	$1,303.00	4	0	$790.00
G11A	Anal & stomal procedures +cscc	$3,064.00	8	1	$706.00
G11B	Anal & stomal procedures -cscc	$1,177.00	4	0	$737.00
G12A	Oth digest sys or pr+cscc/+mal	$6,222.00	13	2	$885.00
G12B	Oth digest sys or pr-cscc-mal	$2,648.00	5	0	$878.00
G40A	Cx thpc gstry+mjr dig dis+cscc	$6,511.00	17	3	$731.00
G40B	Cx thpc gstry+mjr dig dis-cscc	$1,710.00	5	0	$672.00
G41A	Cx thptc gastrsy+n-mjr dig dis	$3,740.00	10	2	$761.00
G41B	Cx thptc gstrsy n-m dig dis,sd	$679.00	4	0	$505.00
G42A	Oth gastroscopy+mjr digest dis	$3,645.00	11	2	$653.00
G42B	Oth gastroscopy+mjr dig dis,sd	$606.00	4	0	$491.00
G43Z	Complx therapeutic colonoscopy	$1,062.00	4	0	$628.00
G44A	Other colonoscopy+cscc/cx pr	$3,787.00	12	2	$630.00
G44B	Other colonoscopy-cscc/cx pr	$1,960.00	5	0	$799.00
G44C	Other colonoscopy, sameday	$675.00	4	0	$575.00

G45A	Other gastrpy+n-mjr digest dis	$2,737.00	9	1	$617.00
G45B	Other gastrpy+n-mjr dig dis,sd	$487.00	4	0	$423.00
G60A	Digestive malignancy + cscc	$4,784.00	17	3	$570.00
G60B	Digestive malignancy - cscc	$2,158.00	7	1	$597.00
G61A	Gi haemorrhage a<65+cscc/a>64	$2,725.00	9	1	$617.00
G61B	Gi haemorrhage a<65 - cscc	$923.00	4	0	$481.00
G62Z	Complicated peptic ulcer	$2,714.00	11	2	$505.00
G63Z	Uncomplicated peptic ulcer	$2,175.00	8	1	$565.00
G64Z	Inflammatory bowel disease	$832.00	4	0	$474.00
G65A	Gi obstruction + cc	$4,544.00	17	3	$542.00
G65B	Gi obstruction - cc	$2,080.00	7	1	$614.00
G66A	Abdmnl pain/mesentrc adents+cc	$2,639.00	10	2	$536.00
G66B	Abdmnl pain/mesentrc adents-cc	$1,127.00	5	0	$532.00
G67A	Oesphs, gastr & mis dig a>9+cscc	$3,936.00	14	2	$562.00
G67B	Oesphs, gastr & mis dig a>9-cscc	$1,804.00	7	1	$571.00
G68A	Gastroenteritis a<10 + cc	$760.00	6	0	$291.00
G68B	Gastroenteritis a<10 - cc	$620.00	4	0	$425.00
G69Z	Oesphs & misc dig sys dis a<10	$976.00	5	0	$436.00
G70A	Other digestive system diag+cc	$3,443.00	13	2	$549.00
G70B	Other digestive system diag-cc	$1,088.00	4	0	$519.00
H01A	Pancreas, liver & shunt pr+ccc	$22,234.00	35	6	$1,100.00
H01B	Pancreas, liver & shunt pr+smcc	$11,958.00	17	3	$1,100.00
H01C	Pancreas, liver & shunt pr -cc	$8,865.00	12	2	$1,100.00
H02A	Major biliary tract proc+malig	$14,623.00	28	5	$945.00
H02B	Mjr biliary tract pr-mal+cscc	$12,003.00	24	4	$918.00
H02C	Mjr biliary tract pr-mal-cscc	$4,414.00	6	0	$1,100.00
H03A	Cholecystectmy+closed cde+cscc	$7,719.00	19	3	$735.00
H03B	Cholecystectmy+closed cde-cscc	$4,793.00	7	1	$1,056.00
H04A	Cholecystectmy-closed cde+cscc	$6,076.00	12	2	$916.00
H04B	Cholecystectmy-closed cde-cscc	$3,423.00	4	0	$1,100.00
H05A	Hepatobiliary diagntic pr+cscc	$9,664.00	25	4	$724.00
H05B	Hepatobiliary diagntic pr-cscc	$2,752.00	4	0	$1,100.00
H06Z	Oth heptobilry & pancrs or pr	$6,124.00	7	1	$1,100.00
H40Z	Endospic pr bleed oes varices	$2,334.00	8	1	$594.00
H41A	Ercp cx theraputic pr + cscc	$7,123.00	18	3	$719.00
H41B	Ercp cx theraputic pr - cscc	$3,289.00	6	0	$900.00
H42A	Ercp oth theraputic pr + cscc	$6,669.00	18	3	$674.00
H42B	Ercp oth theraputic pr - cscc	$2,423.00	4	0	$910.00
H60A	Cirrhosis & alc hepatitis +ccc	$7,780.00	30	5	$524.00

H60B	Cirrhosis & alc hepatitis+cscc	$3,174.00	12	2	$548.00
H60C	Cirrhosis & alc hepatitis-cscc	$1,400.00	5	0	$522.00
H61A	Mal heptbilr s,pncrs a>69+cscc	$6,611.00	23	4	$587.00
H61B	Mal hepbil a<70+cscc/a>69-cscc	$4,050.00	14	2	$591.00
H61C	Mal heptbilr s,pncrs a<70-cscc	$1,900.00	6	0	$655.00
H62A	Disorders pancreas-malig+cscc	$6,565.00	21	3	$633.00
H62B	Disorders pancreas-malig-cscc	$2,109.00	7	1	$596.00
H63A	Dsrd lvr-mal,cirr,alc hep+cscc	$5,138.00	19	3	$550.00
H63B	Dsrd lvr-mal,cirr,alc hep-cscc	$1,332.00	5	0	$527.00
H64A	Disorders of biliary tract +cc	$4,410.00	15	2	$610.00
H64B	Disorders of biliary tract -cc	$1,523.00	6	0	$568.00
I01Z	Bil/mlti mjr jt pr lwr extrmty	$12,447.00	19	3	$1,094.00
I02A	Mcrvas tt/skin graft+cscc-hand	$17,618.00	35	7	$749.00
I02B	Skin graft -cscc -hand	$4,942.00	7	1	$1,100.00
I03A	Hip revision + cscc	$16,870.00	33	5	$927.00
I03B	Hip replac+cscc/hip revsn-cscc	$12,155.00	20	3	$1,100.00
I03C	Hip replacement - cscc	$9,759.00	13	2	$1,100.00
I04A	Knee replacemt & reattach+ccc	$11,987.00	25	4	$913.00
I04B	Knee replacemt & reattach-ccc	$8,577.00	13	2	$1,100.00
I05Z	Oth mjr jnt replace & limb reatt	$6,343.00	10	2	$1,100.00
I06Z	Spinal fusion + deformity	$14,742.00	21	3	$1,100.00
I07Z	Amputation	$12,458.00	33	5	$702.00
I08A	Other hip & femur proc + cscc	$12,793.00	33	5	$754.00
I08B	Other hip & femur pr a>54-cscc	$7,620.00	15	2	$958.00
I08C	Other hip & femur pr a<55-cscc	$3,783.00	4	0	$1,100.00
I09A	Spinal fusion + cscc	$16,052.00	24	4	$1,100.00
I09B	Spinal fusion - cscc	$9,450.00	13	2	$1,100.00
I10A	Other back & neck procs + cscc	$10,845.00	19	3	$956.00
I10B	Other back & neck procs - cscc	$6,075.00	8	1	$1,100.00
I11Z	Limb lengthening procedures	$5,424.00	13	2	$622.00
I12A	Infc/infm bone/jnt+misc pr+ccc	$15,284.00	35	8	$626.00
I12B	Infc/infm bone/jnt+misc pr+scc	$7,558.00	22	4	$635.00
I12C	Infc/infm bne/jnt+misc pr-cscc	$3,249.00	6	0	$934.00
I13A	Humer,tibia,fibul,ankl pr+cscc	$8,901.00	23	4	$723.00
I13B	Humer,tib,fib,ank pr a>59-cscc	$4,425.00	8	1	$983.00
I13C	Humer,tib,fib,ank pr a<60-cscc	$2,856.00	4	0	$1,100.00
I14Z	Stump revision	$2,662.00	7	1	$532.00
I15Z	Cranio-facial surgery	$6,635.00	10	2	$1,100.00
I16Z	Other shoulder procedures	$2,736.00	4	0	$1,100.00

I17Z	Maxillo-facial surgery	$3,025.00	4	0	$1,100.00
I18Z	Knee procedures	$1,750.00	4	0	$1,068.00
I19Z	Other elbow, forearm procs	$2,465.00	4	0	$1,093.00
I20Z	Foot procedures	$2,443.00	4	0	$1,100.00
I21Z	Loc ex, rem int fix dev hp & fmr	$1,852.00	4	0	$760.00
I22Z	Major wrist, hand, thumb procs	$1,991.00	4	0	$1,079.00
I23Z	Loc ex, rem int fix dev-hp & fmr	$1,428.00	4	0	$811.00
I24Z	Arthroscopy	$1,625.00	4	0	$904.00
I25Z	Bone, joint dxtic pr inc biopsy	$4,340.00	14	2	$579.00
I26Z	Other wrist, hand procedures	$1,382.00	4	0	$816.00
I27Z	Soft tissue procedures	$2,053.00	4	0	$836.00
I28A	Other connect tissue procs +cc	$8,109.00	22	4	$682.00
I28B	Other connect tissue procs -cc	$2,243.00	4	0	$1,005.00
I60Z	Femor shaft & open condyl fract	$3,711.00	13	2	$606.00
I61Z	Other femoral fractures	$9,182.00	34	6	$549.00
I62A	Fract pelvis & femoral neck +ccc	$10,311.00	35	6	$563.00
I62B	Fract pelvis & femoral neck +scc	$7,717.00	25	4	$621.00
I62C	Fract pelvis & femoral neck-cscc	$5,321.00	18	3	$622.00
I63Z	Spr,str & dsloc hip,pelvis&thigh	$2,459.00	9	1	$582.00
I64A	Osteomyelitis a<65+cscc/a>64	$5,982.00	26	4	$453.00
I64B	Osteomyelitis a<65 -cscc	$1,829.00	12	2	$313.00
I65A	Con tis mal,inc path frac a>64	$6,173.00	22	4	$562.00
I65B	Con tis mal,inc path frac a<65	$4,164.00	16	3	$545.00
I66A	Oth con tis dsr a>64/a<65+cscc	$1,826.00	7	1	$524.00
I66B	Oth conntve tiss dsr a<65-cscc	$663.00	4	0	$491.00
I67A	Septic arthritis + cscc	$3,403.00	16	3	$431.00
I67B	Septic arthritis - cscc	$2,883.00	13	2	$465.00
I68A	N-s nck,bck-pn pr a<75+cc/a>74	$5,078.00	18	3	$578.00
I68B	N-surg neck,back-pn pr a<75-cc	$2,170.00	7	1	$605.00
I68C	N-surg neck & back+pain pr/myel	$1,251.00	4	0	$589.00
I69A	Bne dis & spcfc arthro a>74+cscc	$8,235.00	29	5	$586.00
I69B	Bne dis & spcfc arthro a>74-cscc	$3,239.00	11	2	$604.00
I69C	Bone dis & specfc arthrop a<75	$1,472.00	6	0	$525.00
I70Z	Non-specific arthropathies	$1,974.00	6	0	$561.00
I71A	Musculotendinous dsrd a>69 +cc	$4,958.00	17	3	$580.00
I71B	Musctendns dsr a<70+cc/a>69-cc	$2,439.00	8	1	$606.00
I71C	Musculotendinous dsrd a<70 -cc	$1,236.00	5	0	$553.00
I72A	Tendn,myot & burs a<80+cscc/a>79	$4,409.00	17	3	$540.00
I72B	Tendntis,myots & burs a<80-cscc	$1,196.00	4	0	$530.00

I73A	Aftcare con tis drsd a>59+cscc	$7,982.00	34	6	$478.00
I73B	Aftcare ct a<60+cscc/a>59-cscc	$3,545.00	12	2	$573.00
I73C	Aftcare con tis drsd a<60-cscc	$1,645.00	6	0	$550.00
I74A	Inj frarm,wr,hand,foot a>74+cc	$6,831.00	25	4	$544.00
I74B	Inj hand, foot a>74-cc/a<75+cc	$3,284.00	11	2	$590.00
I74C	Inj frarm,wr,hand,foot a<75-cc	$829.00	4	0	$560.00
I75A	Inj sh, arm,elb,kn,leg a>64+cc	$8,512.00	30	5	$576.00
I75B	Inj arm, leg a>64-cc/a<65+cc	$4,003.00	14	2	$594.00
I75C	Inj sh, arm,elb,kn,leg a<65-cc	$1,155.00	4	0	$560.00
I76A	Other conn tiss dsrds a>69 +cc	$5,280.00	21	3	$510.00
I76B	Oth con tis ds a<70+cc/a>69-cc	$2,021.00	8	1	$534.00
I76C	Other conn tiss dsrds a<70 -cc	$995.00	4	0	$494.00
J01Z	Microvasc tiss transf skn/brst	$12,682.00	18	3	$1,100.00
J02A	L lmb+skin graft+ulcr/cels+ccc	$20,176.00	35	11	$589.00
J02B	L lmb+skin graft+ulcr/cels-ccc	$10,322.00	28	5	$699.00
J03A	L lmb+skn graft-ulcr/cels+cscc	$8,959.00	27	4	$599.00
J03B	L lmb+skn graft-ulcr/cels-cscc	$3,304.00	8	1	$692.00
J04A	L lmb-skn graft+ulcr/cels+cscc	$13,080.00	35	7	$627.00
J04B	L lmb-skn graft+ulcr/cels-cscc	$5,035.00	13	2	$732.00
J05Z	L lmb-skin graft-ulcer/cells	$2,262.00	5	0	$696.00
J06A	Major pr malig breast condtns	$4,310.00	6	0	$1,100.00
J06B	Major pr non-malig breast cnds	$3,208.00	4	0	$1,100.00
J07A	Minor pr malig breast condns	$1,775.00	4	0	$978.00
J07B	Minor pr non-malig breast cnds	$1,336.00	4	0	$783.00
J08A	Oth skn grf & dbrdmnt pr+cscc	$5,804.00	16	3	$651.00
J08B	Oth skn grf & dbrdmnt pr-cscc	$1,759.00	4	0	$831.00
J09Z	Perianal & pilonidal pr	$1,589.00	4	0	$769.00
J10Z	Skn,subc tis & brst plastic pr	$1,825.00	4	0	$879.00
J11Z	Other skin, subc tis & brst pr	$1,062.00	4	0	$629.00
J60A	Skin ulcers a>64	$6,396.00	23	4	$578.00
J60B	Skin ulcers a<65	$2,315.00	11	2	$456.00
J61Z	Severe skin disorders	$1,845.00	7	1	$518.00
J62A	Malig breast disorder a>69 +cc	$5,154.00	17	3	$638.00
J62B	Mal brst disrd a>69-cc/a<70+cc	$2,066.00	8	1	$569.00
J62C	Malig breast disorder a<70 -cc	$816.00	4	0	$644.00
J63Z	Non-malignant breast disorders	$1,302.00	4	0	$544.00
J64A	Cellulitis a>59 + cscc	$6,686.00	23	4	$584.00
J64B	Cellulitis a>59 -cscc / a<60	$2,944.00	11	2	$562.00
J65A	Trauma to skn,sub tis & bst a>69	$4,412.00	16	3	$564.00

J65B	Trauma to skn,sub tis & bst a<70	$1,082.00	4	0	$484.00
J66A	Moderate skin disorders + cscc	$5,405.00	20	3	$559.00
J66B	Moderate skin disorders - cscc	$2,529.00	9	1	$601.00
J67A	Minor skin disorders + cc	$3,635.00	13	2	$575.00
J67B	Minor skin disorders - cc	$955.00	4	0	$523.00
K01Z	Diabetic foot	$14,679.00	35	7	$654.00
K02Z	Pituitary procedures	$11,297.00	15	2	$1,100.00
K03Z	Adrenal procedures	$7,293.00	10	2	$1,100.00
K04Z	Major procedures for obesity	$4,534.00	4	0	$1,100.00
K05Z	Parathyroid procedures	$3,628.00	4	0	$1,100.00
K06Z	Thyroid procedures	$3,879.00	4	0	$1,100.00
K07Z	Obesity procedures	$5,061.00	7	1	$1,065.00
K08Z	Thyroglossal procedures	$2,218.00	4	0	$1,100.00
K09Z	Other endcrn, nutr & meta or pr	$5,558.00	9	1	$1,083.00
K40Z	Endosc/invest pr metab dsdr-cc	$847.00	4	0	$607.00
K60A	Diabetes + cscc	$7,021.00	24	4	$588.00
K60B	Diabetes - cscc	$2,305.00	8	1	$593.00
K61Z	Severe nutritional disturbance	$7,722.00	29	5	$543.00
K62A	Misc metabolic disorders + ccc	$6,951.00	26	4	$550.00
K62B	Misc metblc dsrds+scc/a>74-scc	$2,738.00	10	2	$600.00
K62C	Misc metabolic dsrds-cscc a<75	$861.00	4	0	$534.00
K63Z	Inborn errors of metabolism	$1,763.00	7	1	$546.00
K64A	Endocrine disorders + cscc	$6,540.00	20	3	$666.00
K64B	Endocrine disorders - cscc	$3,379.00	5	0	$1,100.00
L02Z	Oper insert peri cath dialysis	$2,419.00	6	0	$749.00
L03A	Kdny,urt & mjr bldr pr npsm+cscc	$14,791.00	24	4	$1,100.00
L03B	Kdny,urt & mjr bldr pr npsm-cscc	$8,139.00	11	2	$1,100.00
L04A	Kdy,urt & mjr bldr pr n-npm+cscc	$8,347.00	19	3	$828.00
L04B	Kdy,urt & mjr bldr pr n-npm-cscc	$2,934.00	4	0	$1,100.00
L05A	Tranureth prostatectomy +cscc	$9,097.00	24	4	$712.00
L05B	Tranureth prostatectomy -cscc	$4,080.00	7	1	$1,056.00
L06A	Minor bladder procedures+cscc	$6,761.00	18	3	$714.00
L06B	Minor bladder procedures -cscc	$2,021.00	4	0	$936.00
L07A	Transurethral procs + cscc	$4,653.00	14	2	$605.00
L07B	Transurethral procs - cscc	$1,410.00	4	0	$834.00
L08A	Urethral procedures + cc	$2,279.00	7	1	$585.00
L08B	Urethral procedures - cc	$1,326.00	4	0	$764.00
L09A	Oth kidny & urnry tract pr+ccc	$16,575.00	35	6	$910.00
L09B	Oth kidny & urnry tract pr+scc	$6,708.00	16	3	$778.00

L09C	Oth kidny & urnry trct pr-cscc	$2,815.00	4	0	$1,100.00
L40Z	Ureteroscopy	$1,567.00	4	0	$843.00
L41Z	Cystourethroscopy -cc	$969.00	4	0	$682.00
L42Z	Esw lithotripsy+urinary stones	$2,447.00	4	0	$1,100.00
L60A	Renal failure + ccc	$10,527.00	29	5	$723.00
L60B	Renal failure + scc/a>69-scc	$5,028.00	15	2	$677.00
L60C	Renal failure a<70 - cscc	$2,525.00	8	1	$651.00
L61Z	Admit for renal dialysis	$329.00	4	0	$325.00
L62A	Kdny & unry trct neoplasms +cscc	$6,183.00	22	4	$584.00
L62B	Kdny & unry trct neoplasms -cscc	$1,493.00	4	0	$705.00
L63A	Kdny & unry trct infs a>69+ccc	$7,518.00	26	4	$587.00
L63B	Kdny & unry trct infs a>69-ccc	$3,794.00	13	2	$625.00
L63C	Kidny & urnry tract infcs a<70	$1,864.00	7	1	$556.00
L64Z	Urinary stones & obstruction	$1,370.00	4	0	$647.00
L65A	Kdny & unry tr sgns & symps+cscc	$4,466.00	16	3	$562.00
L65B	Kdny & unry tr sgns & symps-cscc	$1,393.00	5	0	$581.00
L66Z	Urethral stricture	$1,086.00	4	0	$636.00
L67A	Oth kidny & urnry tract dx+ccc	$5,819.00	22	4	$521.00
L67B	Oth kidny & urnry tract dx+scc	$3,074.00	10	2	$608.00
L67C	Oth kidny & urnry trct dx-cscc	$738.00	4	0	$487.00
M01Z	Major male pelvic procedures	$8,284.00	9	1	$1,100.00
M02A	Transurethral prostectomy+cscc	$5,954.00	15	2	$763.00
M02B	Transurethral prostectomy-cscc	$3,424.00	6	0	$1,094.00
M03A	Penis procedures + cc	$3,546.00	7	1	$828.00
M03B	Penis procedures - cc	$1,732.00	4	0	$960.00
M04A	Testes procedures + cc	$3,262.00	9	1	$648.00
M04B	Testes procedures - cc	$1,530.00	4	0	$930.00
M05Z	Circumcision	$953.00	4	0	$623.00
M06A	Oth male reprod sys or pr +mal	$1,864.00	4	0	$1,087.00
M06B	Oth male reprod sys or pr -mal	$1,557.00	4	0	$736.00
M40Z	Cystourethroscopy - cc	$740.00	4	0	$535.00
M60A	Malignancy, male repr sys+cscc	$6,226.00	24	4	$534.00
M60B	Malignancy, male repr sys-cscc	$834.00	4	0	$494.00
M61A	Benign prostatic hypertry+cscc	$3,039.00	11	2	$554.00
M61B	Benign prostatic hypertry-cscc	$741.00	4	0	$474.00
M62A	Inflammation male reprd sys+cc	$3,057.00	12	2	$540.00
M62B	Inflammation male reprd sys-cc	$1,287.00	5	0	$545.00
M63Z	Sterilisation, male	$850.00	4	0	$635.00
M64Z	Other male reproductive sys dx	$889.00	4	0	$473.00

N01Z	Pelvic evscrtn & radcl vlvctmy	$8,722.00	16	3	$985.00
N02A	Utrn,adnx pr+ovrn/adnxl mal+cc	$10,144.00	20	3	$957.00
N02B	Utrn,adnx pr+ovrn/adnxl mal-cc	$5,418.00	9	1	$1,082.00
N03A	Utrn,adnx pr-ovrn/adnxl mal+cc	$7,736.00	16	3	$914.00
N03B	Utrn,adnx pr-ovrn/adnxl mal-cc	$4,444.00	7	1	$1,100.00
N04Z	Hysterectomy for non-malignanc	$4,890.00	8	1	$1,100.00
N05A	Ooph & com fal tube pr nmal+cscc	$5,335.00	10	2	$972.00
N05B	Ooph & com fal tube pr nmal-cscc	$3,256.00	4	0	$1,100.00
N06Z	Fem repr sys reconstructive pr	$3,481.00	6	0	$1,081.00
N07Z	Oth utern & adnexa pr for nmal	$1,375.00	4	0	$832.00
N08Z	Endoscopic procs, fem repr sys	$1,283.00	4	0	$859.00
N09Z	Conistn,vagina,cervix & vulva pr	$1,039.00	4	0	$631.00
N10Z	Dxc curettge, dxc hysteroscopy	$987.00	4	0	$662.00
N11A	Oth fem rep s pr a>64/+mal/+cc	$2,719.00	11	2	$432.00
N11B	Oth fem rep sys pr a<65-mal-cc	$641.00	4	0	$406.00
N60A	Malignancy fem reprod sys+cscc	$4,214.00	16	3	$546.00
N60B	Malignancy fem reprod sys-cscc	$1,578.00	6	0	$613.00
N61Z	Infections, female reprod syst	$1,461.00	6	0	$506.00
N62A	Mnstrl & oth fem repr sys dis+cc	$1,241.00	5	0	$496.00
N62B	Mnstrl & oth fem repr sys dis-cc	$664.00	4	0	$480.00
Q01Z	Splenectomy	$8,419.00	15	2	$982.00
Q02A	Oth or pr bld & bld frm org+cscc	$7,992.00	21	3	$704.00
Q02B	Oth or pr bld & bld frm org-cscc	$1,721.00	4	0	$816.00
Q60A	Reticlendothll & imnty dsrd+cscc	$4,169.00	14	2	$623.00
Q60B	Reticlendothll & imnty dsrd-cscc	$670.00	4	0	$442.00
Q61A	Red blood cell disders + ccc	$6,615.00	22	4	$616.00
Q61B	Red blood cell disders + scc	$2,749.00	10	2	$591.00
Q61C	Red blood cell disders - cscc	$822.00	4	0	$552.00
Q62A	Coagulation disorders a>69	$2,248.00	8	1	$556.00
Q62B	Coagulation disorders a<70	$995.00	4	0	$515.00
R01A	Lymphma & leukma+mjr or pr +cscc	$18,845.00	35	7	$865.00
R01B	Lymphma & leukma+mjr or pr -cscc	$5,409.00	9	1	$1,062.00
R02A	Oth nplstc dsrd+mjr or pr+cscc	$11,622.00	22	4	$981.00
R02B	Oth nplstc dsrd+mjr or pr-cscc	$5,246.00	8	1	$1,100.00
R03A	Lymphma leukma+oth or pr +cscc	$14,573.00	35	7	$667.00
R03B	Lymphma leukma+oth or pr -cscc	$2,492.00	5	0	$896.00
R04A	Oth nplstc dsrd+oth or pr+cscc	$7,513.00	18	3	$759.00
R04B	Oth nplstc dsrd+oth or pr-cscc	$2,565.00	5	0	$904.00
R60A	Acute leukaemia + ccc	$16,616.00	35	8	$697.00

R60B	Acute leukaemia + scc	$3,895.00	13	2	$627.00
R60C	Acute leukaemia - cscc	$1,670.00	5	0	$690.00
R61A	Lymphma & n-acute leukaemia+ccc	$10,642.00	35	6	$584.00
R61B	Lymphma & n-acute leukaemia-ccc	$2,890.00	9	1	$658.00
R61C	Lymphoma/n-a leukaemia,sameday	$361.00	4	0	$324.00
R62A	Other neoplastic disorders +cc	$5,138.00	18	3	$572.00
R62B	Other neoplastic disorders -cc	$2,156.00	8	1	$514.00
R63Z	Chemotherapy	$402.00	4	0	$390.00
T01A	Or proc infect & paras dis+ccc	$16,820.00	35	7	$747.00
T01B	Or proc infect & paras dis+smcc	$6,544.00	19	3	$642.00
T01C	Or proc infect & paras dis-cc	$3,977.00	9	1	$747.00
T60A	Septicaemia + cscc	$7,864.00	23	4	$688.00
T60B	Septicaemia - cscc	$4,020.00	13	2	$620.00
T61A	Pstop & psttr inf+cscc/a>54-cscc	$3,747.00	14	2	$536.00
T61B	Postop & posttr infect a<55-cscc	$2,052.00	8	1	$539.00
T62A	Fever of unknown origin + cc	$3,214.00	12	2	$555.00
T62B	Fever of unknown origin - cc	$1,719.00	7	1	$564.00
T63A	Viral illness a>59	$3,293.00	11	2	$610.00
T63B	Viral illness a<60	$1,320.00	5	0	$567.00
T64A	Oth infectous & parstic dis+cscc	$4,791.00	19	3	$523.00
T64B	Oth infectous & parstic dis-cscc	$2,129.00	8	1	$548.00
U40Z	Mental health treat,samedy+ect	$302.00	4	0	$259.00
U60Z	Mental health treat,samedy-ect	$268.00	4	0	$268.00
U61A	Schizophrenia disorders+mhls	$10,117.00	35	11	$294.00
U61B	Schizophrenia disorders-mhls	$9,134.00	35	6	$481.00
U62B	Par & acute psych dsrd-cscc-mhls	$8,232.00	34	6	$488.00
U63A	Mjr affect dsrd+cscc/a>69-cscc	$11,716.00	35	7	$527.00
U63B	Major affective dsrd a<70-cscc	$10,425.00	35	6	$538.00
U64Z	Oth affect & somatoform dsrd	$10,178.00	35	6	$571.00
U67Z	Personlty dsrd & acute reactions	$10,023.00	35	6	$569.00
V60Z	Alcohol intoxicatn & withdrwl	$2,449.00	10	2	$528.00
V61A	Drug intoxictn & withdrawal+cc	$2,197.00	10	2	$467.00
V61B	Drug intoxictn & withdrawal-cc	$1,203.00	6	0	$433.00
V62A	Alcohol use dsrd & dependence	$8,693.00	31	5	$570.00
V62B	Alcohol use dsrd & dependnc+sd	$263.00	4	0	$263.00
V63Z	Opioid use dsrd & dependence	$2,607.00	10	2	$528.00
V64Z	Other drug use disord & depend	$2,523.00	10	2	$512.00
W02Z	Hip,femr & limb pr mult sig trma	$20,291.00	35	9	$727.00
W04Z	Othr or pr for mult sig trauma	$7,496.00	31	5	$484.00

W61Z	Multiple trauma - signif procs	$8,389.00	29	5	$595.00
X01Z	Mic tt/skin grafts inj lwr lmb	$8,268.00	24	4	$639.00
X02Z	Mic tt/skin grafts inj to hand	$2,540.00	4	0	$863.00
X03Z	Mic tt/skin grafts other inj	$5,479.00	14	2	$675.00
X04A	Other pr inj lwr lmb a>59/+cc	$6,646.00	18	3	$658.00
X04B	Other pr inj lowr limb a<60-cc	$2,245.00	4	0	$846.00
X05Z	Other pr for injuries to hand	$1,842.00	4	0	$687.00
X06A	Other pr other injuries + cscc	$7,717.00	18	3	$768.00
X06B	Other pr other injuries - cscc	$2,677.00	4	0	$988.00
X60A	Injuries a>64 + cc	$5,985.00	21	3	$575.00
X60B	Injuries a>64 - cc	$2,981.00	10	2	$602.00
X60C	Injuries a<65	$1,165.00	5	0	$489.00
X61Z	Allergic reactions	$1,125.00	4	0	$618.00
X62A	Poisng/toxc eff drugs a>59/+cc	$3,080.00	10	2	$639.00
X62B	Poisng/toxc eff drugs a<60 -cc	$549.00	4	0	$384.00
X63A	Sequelae of treatmnt+cscc	$3,997.00	14	2	$589.00
X63B	Sequelae of treatmnt-cscc	$1,496.00	5	0	$568.00
X64A	Ot inj,pois & tox ef dx a>59/+cc	$2,031.00	11	2	$387.00
X64B	Ot inj,pois & tox eff dx a<60-cc	$153.00	4	0	$139.00
Y02B	Oth Burn+Skn Gr A<65-Cscc-Comp	$3,523.00	7	1	$846.00
Z01A	Or pr+dx oth cnt hlth srv+cscc	$2,775.00	10	2	$529.00
Z01B	Or pr+dx oth cnt hlth srv-cscc	$1,231.00	4	0	$729.00
Z40Z	Follow up aftr treat+endoscopy	$644.00	4	0	$546.00
Z61Z	Signs and Symptoms	$1,411.00	5	0	$530.00
Z62Z	Follow up aftr treat-endoscopy	$588.00	4	0	$409.00
Z63A	Other Aftercare w Catastrophic or Severe cc	$5,119.00	17	3	$605.00
Z63B	Other aftercare - Cscc	$2,125.00	8	1	$581.00
Z64A	Other factors influencing health status >79	$3,822.00	19	3	$401.00
Z64B	Other factors influencing health status <80	$516.00	4	0	$348.00
901Z	Extensive O.R. Procedure Unrelated to Principal Diagnosis	$6,047.00	11	2	$918.00

Table 3

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

SAME-DAY SERVICES DAY SURGERY FACILITY

Accommodation
The band into which services fall will be determined in accordance with the Day Only Procedures Manual.

Item No.	Service description	Max fee (excl GST)
PR410	Band 1: including gastrointestinal endoscopy, some minor surgical and non surgical procedures not normally requiring anaesthetic.	$320.80
PR420	Band 2: including procedures other than Band 1 performed under local anaesthetic with no sedation. Theatre time less than 1 hour.	$381.90
PR430	Band 3: including procedures other than Band 1 performed under a general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour.	$446.20
PR440	Band 4: including procedures other than Band 1 performed under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.	$473.00

Theatre
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.	Service description	Max fee - excl GST
PRT1A	1A	$184.30
PRT01	1	$368.60
PRT02	2	$470.40
PRT03	3	$654.00
PRT04	4	$946.10
PRT05	5	$1,214.00
PRT06	6	$1,598.60
PRT07	7	$2,186.90
PRT08	8	$2,334.20
PRT9A	9A	$2,714.70
PRT09	9	$3,114.00
PRT10	10	$4,076.20
PRT11	11	$5,784.50
PRT12	12	$6,210.70
PRT13	13	$5,873.00
PRT50	Dental minor	$348.30
PRT55	Dental major	$628.40

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