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CONTENTS

STATE GOVERNMENT INSTRUMENTS
Planning, Development and Infrastructure Act 2016—REPUBLISHED 1618
Return to Work Act 2014 1628

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STATE GOVERNMENT INSTRUMENTS

[REPUBLISHED]

The following notice published in the *South Australian Government Gazette* No. 32, dated 11 June 2026, on pages 1602 to 1611, under the heading *Planning, Development and Infrastructure Act 2016*, was published with an error and should be replaced with the following:

PLANNING, DEVELOPMENT AND INFRASTRUCTURE ACT 2016

South Australia

Planning, Development and Infrastructure (Fees) Notice 2026

under the *Planning, Development and Infrastructure Act 2016*

1—Short title

This notice may be cited as the *Planning, Development and Infrastructure (Fees) Notice 2026.*

Note—

This is a fee notice made in accordance with the *Legislation (Fees) Act 2019*.

2—Commencement

This notice has effect on 1 July 2026.

3—Interpretation

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

Act means the *Planning, Development and Infrastructure Act 2016*;

allotment does not include an allotment for road or open space requirements;

development cost does not include any fit-out costs;

regulations means the following:

(a) the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019*;

(b) the *Planning, Development and Infrastructure (Fees, Charges and Contributions) Regulations 2019*;

(c) the *Planning, Development and Infrastructure (General) Regulations 2017*.

(2) Words and expressions used in the regulations and in this fee notice have the same respective meanings in this notice as they have in the regulations.

(3) Subclause (2) does not apply to the extent that the context or subject matter otherwise indicates or requires.

4—Fees payable

(1) The fees set out in Schedule 1 are prescribed for the purposes of the Act and the regulations and are payable as specified in that Schedule.

(2) A fee set out in Schedule 1 item 8 is payable to the body specified in relation to the fee.

(3) Subject to subclauses (4) and (5), if an application, matter or circumstance falls within more than 1 item under Schedule 1, then the fee under each such item applies and those fees in total will be payable.

(4) If planning consent is sought for development comprising more than 1 element—

(a) a fee is not payable under Schedule 1 item 6 for each element of the development; and

(b) the fee payable under Schedule 1 item 6 is the highest fee applying to a single element of the development; and

(c) if the relevant fee is based on the total development cost, the fee payable will be based on the total cost of all elements of the development.

(5) If an application for planning consent must be referred to the same body under more than 1 item of Schedule 9 of the *Planning, Development and Infrastructure (General) Regulations 2017*, then only 1 prescribed fee under Schedule 1 item 8 is payable with respect to the referral of the application to that body.

(6) A reference in subclause (5) to a prescribed fee extends to a prescribed fee that, although payable, was waived (in whole or in part) by a relevant authority.

(7) Subject to subclause (8) if a lodgement fee has been paid in respect of an application for planning consent or building consent for a development, no lodgement fee is payable for any other consents related to that application or for the issue of the final development approval in respect of that development.

(8) If a lodgement fee has been paid in respect of an application under the repealed Act, a lodgement fee under this notice is payable in respect of the first application for consent related to the application under the repealed Act that is lodged electronically via the SA planning portal.

5—Assessment requirements—water and sewerage

(1) A prescribed fee under Schedule 1 item 27 is payable to the South Australian Water Corporation or any other water industry entity identified for the purposes of Section 102(1)(c)(iii) and (1)(d)(vii) of the Act.

(2) The prescribed fee is payable by the person who makes the application to divide the land.

6—Applications relating to certain electricity infrastructure—issue of certificate by Technical Regulator

The prescribed fee under Schedule 1 item 32 is payable to the Technical Regulator for the issue of a certificate required by the *Planning, Development and Infrastructure (General) Regulations 2017* to accompany an application in respect of a proposed development for the purposes of the provision of electricity generating plant with a generating capacity of more than 5 MW that is to be connected to the State's power system.

Schedule 1—Fees

Part 1—Fees regarding applications to the Accreditation Authority

The following fees are payable for the purposes of the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019*:

1	Application to the accreditation authority for accreditation under the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019*, other than where item 2 applies.	$668.00

2	Application to the accreditation authority for accreditation under the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019* where— (a) the person is a member of a professional association or body recognised by the Chief Executive for the purposes of Regulation 16(2)(a) of the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019* and the person is applying as a member of that association or body for a corresponding level of accreditation under Regulation 16(2)(a)(ii) of those regulations; or (b) the person is reapplying for an accreditation previously held under the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019* within the preceding 12 months; or (c) the person is applying for building level 4 accreditation under the building supervisor pathway; or (d) the person has lodged a notification under Section 40 of the *Mutual Recognition Act 1992* for recognition of the person's interstate registration, to carry out that occupation in South Australia	$322.00
3	Application to the accreditation authority under Regulation 19 of the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019*	$215.00
4	Late application fee under Regulation 19(3) of the *Planning, Development and Infrastructure (Accredited Professionals) Regulations 2019*	$71.50
4a	Application to the accreditation authority for enrolment into the accredited professionals scheme core competency assessment course	$585.00

Part 2—Fees relating to development assessment

The following fees are payable in relation to development assessment under the Act (including in connection with the *Planning, Development and Infrastructure (General) Regulations 2017*):

5	Application for outline consent, planning consent or building consent (the ***base amount***)—	
	(a) a lodgement fee	
	(i) if the total development cost is no more than $10,000	$98.50
	(ii) if the total development cost is greater than $10,000 and no more than $50,000	$158.00
	(iii) if the total development cost is greater than $50,000 and no more than $100,000	$178.00
	(iv) if the total development cost is greater than $100,000 and no more than $300,000	$187.00
	(v) if the total development cost is greater than $300,000 and no more than $500,000	$197.00
	(vi) if the total development cost is greater than $500,000 and no more than $700,000	$453.00
	(vii) if the total development cost is greater than $700,000 and no more than $1,000,000	$790.00
	(viii) if the total development cost is greater than $1,000,000 and no more than $5,000,000	$3,442.00

	(ix) if the total development cost is greater than $5,000,000 and no more than $10,000,000	$4,588.00
	(x) if the total development cost is greater than $10,000,000; and	$6,308.00
	(b) if the application is lodged at the principal office of the relevant authority—a processing fee	$95.50
5a	Application for outline consent under Section 120 of the Act	$6,582.00
6	Application for planning consent—	
	(a) if the proposed development is to be assessed as deemed to satisfy development under Section 106 of the Act—	
	(i) if the total development cost is no more than $10,000	$151.00
	(ii) in any other case	$250.00
	(b) if the proposed development is to be assessed on its merits under Section 107 of the Act	$299.00 or 0.125% of the total development cost up to a maximum of $200,000, whichever is the greater
	(c) if the proposed development is restricted development under Section 108(1)(a) of the Act	
	(i) if the proposed development is the division of land	$586.00
	(ii) in any other case	0.25% of the total development cost up to a maximum of $300,000
	(d) if the applicant applies for a review of the decision under Section 110(15) of the Act	$611.00
	(e) if an application for the proposed development is to be determined under Section 115 of the Act—	$2,091.00 plus 0.25% of the total development cost up to a maximum of $500,000
7	Application for planning consent that must be notified—	
	(a) if Section 107(3)(a) applies	$299.00
	(b) if Section 110(2)(a) applies	$299.00
7a	Application for outline consent that must be notified	$299.00
8	Application for outline consent or planning consent that must be referred to 1 or more prescribed bodies under Schedule 9 of the *Planning, Development and Infrastructure (General) Regulations 2017*—	
	(a) for referral to the Commissioner of Highways—	
	(i) if the proposed development involves a change in the use of land	$476.00
	(ii) if the proposed development involves the division of land	$476.00

(b)	for referral to the Environment Protection Authority	
	(i) non-licensable	$885.00
	(ii) licensable	$1,992.00
	(iii) site contamination	$1,639.00
(c)	for referral to the Minister responsible for the administration of the *Heritage* Places *Act 1993*	$476.00
(d)	for referral to the Minister responsible for the administration of the *River Murray Act 2003*	$476.00
(e)	for referral to the Relevant authority under the *Landscape South Australia Act 2019*	$476.00
(f)	for referral to the Chief Executive of the Department of the Minister responsible for the administration of the *Landscape South Australia Act 2019*	$476.00
(g)	for referral to the Coast Protection Board	$476.00
(h)	for referral to the Minister responsible for the administration of the *Historic Shipwrecks Act 1981*	$476.00
(i)	for referral to the Commonwealth Minister responsible for the administration of the *Underwater Cultural Heritage Act 2018* of the Commonwealth	$476.00
(j)	for referral to the Native Vegetation Council	$763.00
(k)	for referral to the Government Architect or Associate Government Architect	$582.00
(l)	for referral to Minister responsible for the administration of the *South Australian Housing Trust Act 1995*	$287.00 plus $179.00 per stage
(m)	for referral to the Minister responsible for the administration of the *Aquaculture Act 2001*	$494.00
(n)	for referral to the South Australian Country Fire Service	$476.00
(o)	for referral to Chief Executive of the Department of the Minister responsible for the administration of the *Petroleum and Geothermal Energy Act 2000*	$390.00
(p)	for referral to the Minister responsible for the administration of the Mining Acts	$390.00
(q)	for referral to the Technical Regulator	$199.00
(r)	for referral to the Airport-operator company for the relevant airport within the meaning of the *Airports Act 1996* of the Commonwealth or, if there is no airport-operator company, Secretary of the Department of the Minister responsible for the administration of the *Airports Act 1996* of the Commonwealth	$476.00
(s)	for referral to the Scheme Coordinator of an infrastructure delivery scheme in operation under Part 13 Division 1 of the Act.	$476.00
9	Application for building consent (a ***building assessment fee***)—	
(a)	for a Class 1 building under the Building Code	$538.00 or 0.25% of the total development cost, whichever is the greater

(b)	for a Class 10 building under the Building Code	$154.00 or 0.25% of the total development cost, whichever is the greater
(c)	for any other class of building under the Building Code—	
(i)	if the total development cost is no more than $20,000	$801.00
(ii)	if the total development cost is greater than $20,000 and no more than $200,000	$801.00 plus 0.4% of the amount determined by subtracting $20,000 from the total development cost
(iii)	if the total development cost is greater than $200,000 and no more than $1,000,000	$1,659.00 plus 0.25% of the amount determined by subtracting $200,000 from the total development cost
(iv)	if the total development cost is greater than $1,000,000	$4,050.00 plus 0.15% of the amount determined by subtracting $1,000,000 from the total development cost
10	Application for building consent (a ***compliance fee***)—	
(a)	for a Class 1 building under the Building Code	$287.00
(aa)	<u>for a Class 1 building under the Building Code that contains a Class 10a building under the same roof</u>	$287.00
(b)	for a swimming pool or swimming pool safety features	$287.00
(c)	for a Class 1 building under the Building Code if the building comprises multiple dwellings	$287.00 for each dwelling
(d)	for a Class 10 building under the Building Code—	
(i)	if the total development cost is no more than $10,000	no fee
(ii)	if the total development cost is greater than $10,000	$95.50
(e)	for any other class of building under the Building Code	Once per building— $287.00 or 0.075% of the total development cost up to a maximum of $2,988.00, whichever is the greater
11	Application for building consent for the demolition of a building	$174.00
11a	Where Regulation 39 of the *Planning, Development and Infrastructure (General) Regulations 2017* applies	20% of the fees payable under items 6 to 11
12	Application for the concurrence of the Commission under Section 118(2)(a) of the Act	$412.00

13	Referral of application to the Commission for an opinion under Section 118(4) of the Act	$412.00
14	Application for a development authorisation under Section 102(1)(c) or (d) of the Act—	
	(a) if the number of allotments resulting from the division is equal to or less than the existing number of allotments, or creates no more than 4 additional allotments and does not involve the creation of a public road	$210.00
	(b) if the division creates more than 4 additional allotments	$210.00 plus $19.10 for each additional allotment created
	(c) if the division involves the creation of a public road (regardless of the number of additional allotments created)	$210.00 plus $19.10 for each additional allotment created
15	Application for final development approval in respect of HomeBuilder development (fee payable to the council for the area in which the proposed development is to be undertaken)	$140.00
16	Advice of the Commission under Regulation 76 of the *Planning, Development and Infrastructure (General) Regulations 2017* (payable by the applicant at the time of lodgement of the application)	$240.00
17	A Certificate of Approval Fee for the purposes of Section 138 of the Act	$1,229.00
18	Application under Section 130 or 131 of the Act (fee payable to the Commission)	$212.00 plus 0.25% of the total development cost up to a maximum of $300,000
19	Amount for public advertisement or notice under Sections 130(12)(a) or 131(13)(a) of the Act (amount payable to the Commission)	An amount determined by the Commission as being appropriate to cover its reasonable costs in giving public advertisement or notice of the application under Sections 130(12)(a) or 131(13)(a) of the Act
20	Application for a variation of a development authorisation previously given that is minor in nature	$151.00
21	Application to assessment panel for review of a prescribed matter under Section 202(1)(b)(i)(A) of the Act	$611.00

Part 3—Fees relating to building activity and use

The following fees are payable in relation to building activity and use (including in connection with the *Planning, Development and Infrastructure (General) Regulations 2017*):

22	Issue of a certificate relating to essential safety provisions under Regulation 94 of the *Planning, Development and Infrastructure (General) Regulations 2017*	$287.00
23	Application for assignment of a classification to a building or a change in the classification of a building under Section 151 of the Act	$202.00
24	Application for a certificate of occupancy under Section 152 of the Act	$59.50

Part 4—Funds and off-set schemes

The following fees are payable in relation to funds and off-set schemes:

25	Rates of contribution under Section 198(1)(d), (2)(c) or (8) of the Act—	
	(a) where the land to be divided is within Greater Adelaide	$10,166.00 for each new allotment or strata lot delineated by the relevant plan that does not exceed 1 hectare in area
	(b) where the land to be divided is within any other part of South Australia	$3,723.00 for each new allotment or strata lot delineated by the relevant plan that does not exceed 1 hectare in area
26	Rates of contribution for the purposes of Section 199(1) of the Act—	
	(a) where the prescribed building is within Greater Adelaide	$10,166.00 for each apartment or allotment delineated by the relevant plan
	(b) where the prescribed building is within any other part of South Australia	$3,723.00 for each apartment or allotment delineated by the relevant plan

Part 5—Other fees

The following fees are also payable:

27	An assessment, or the update of an assessment, under Regulation 79 of the *Planning, Development and Infrastructure (General) Regulations 2017*—	
	(a) in relation to an original assessment	$480.00
	(b) in relation to an updating of the original or a subsequent assessment (including where the update is required because of an amended plan of division)	$138.00
28	Application for design review under Section 121 of the Act	$117.00 plus the reasonable costs of the design panel to provide advice on the application
29	Amount for the purposes of Section 127(6) of the Act	$533.00 for each replacement tree that is not planted
29A	Amount for the purposes of the Urban Tree Canopy Offset Scheme established under Section 197 of the Act—	
	(a) in relation to a small tree	$533.00
	(b) in relation to a medium tree	$1,065.00

	(c) in relation to a large tree	$1,598.00
29B	Amount for the purposes of Schedule 4, Clause 18(1a)(a)(ii) of the *Planning, Development and Infrastructure (General) Regulations 2017*	$533.00 for each replacement tree that is not planted
30	Application for the extension of a development authorisation under Section 126(3) of the Act—	
	(a) if the development authorisation relates to development assessed as restricted development under Section 108(1)(a) of the Act	$151.00
	(b) if the development authorisation relates to development determined under Section 115 of the Act (including development determined under Section 48 of the *Development Act 1993* by virtue of Regulation 11A of the *Planning, Development and Infrastructure (Transitional Provisions) Regulations 2017*)	$10,000 for the first request, with the fee to be double the previously applicable fee for each subsequent request thereafter
	(c) in any other case	$127.00
30a	Application for the extension of a development authorisation under Regulation 104B of the *Planning, Development and Infrastructure (General) Regulations 2017* where the development authorisation relates to development assessed under Section 130 of the Act	$151.00
30b	Application for the extension of a development authorisation under Regulation 108 of the *Planning, Development and Infrastructure (General) Regulations 2017*:	
	(a) if the development authorisation relates to development assessed under Section 131(2)(b) of the Act, and the development is undertaken in partnership or joint venture with a person or body that is not a State agency	$10,000 for the first request, with the fee to be double the previously applicable fee for each subsequent request thereafter
	(b) if the development authorisation relates to development assessed under Section 131(2)(c) of the Act	$10,000 for the first request, with the fee to be double the previously applicable fee for each subsequent request thereafter
	(c) in any other case	$151.00
31	Request for initiation of infrastructure scheme under Section 163(3)(b) of the Act	$4,387.00
32	Certificate from Technical Regulator	$480.00
33	Application to register an agreement under Section 192 or 193 of the Act	$95.50
34	Fee for the purposes of Section 192(7) or 193(7) of the Act	$17.80
35	Fee for approval under Section 197(5) of the Act	$445.00
36	Application for the approval of the Minister under Section 235 of the Act	$190.00

37	Application for approval of building envelope plan under Regulation 19A(1) of the *Planning, Development and Infrastructure (General) Regulations 2017*	$210.00 plus $19.10 for each allotment delineated under the building envelope plan
38	Fee for consideration and publication of building envelope plan under Regulation 19A(3) and (4) of the *Planning, Development and Infrastructure (General) Regulations 2017* (payable by applicant at the time of making application for approval of building envelope plan)	$240.00
39	Fee for registration as a Local Design Review Administrator under the Minister's Design Review scheme established under Section 121 of the Act	$646.00
40	Fee for registration an Independent Design Review Administrator under the Minister's Design Review scheme established under Section 121 of the Act	$375.00
41	Fee for consideration of an amendment to the Planning and Design Code in relation to—	$6,449.00
	(a) a proposal to initiate under Section 73(2)(b) of the Act; or	
	(b) lodgement of a complying change under Section 75 of the Act	
42	Fee for the administration and management of a proposed amendment to the Planning and Design Code, where approval of the Minister to initiate the amendment has been granted under Section 73(2)(b) of the Act:	
	(a) if the proposed amendment is determined to be simple in nature	$4,925.00
	(b) if the proposed amendment is determined to be moderately complex in nature	$23,921.00
	(c) if the proposed amendment is determined to be complex in nature	$33,420.00
43	Fee for the publication of consultation of a proposed amendment of the Planning and Design Code under Section 73(2)(b) or Section 75 of the Act	$10,202.00
44	Fee for the consideration by the Minister of a proposed amendment to the Planning and Design Code—	
	(a) under Section 73(2)(b) of the Act:	
	(i) where the proposed amendment is determined to be simple in nature	$4,924.00
	(ii) where the proposed amendment is determined to be moderately complex in nature	$23,920.00
	(iii) where the proposed amendment is determined to be complex in nature	$33,420.00
	(b) under Section 75 of the Act	$4,924.00
45	Fee for administration of implementing a code amendment adopted by the Minister under Section 73(2)(b) or Section 75 of the Act	$11,491.00
46	Fee for accredited professionals acting in a private capacity to use the SA Planning Portal to assess development applications	$54.50 per consent decision made in the preceding quarter

Signed by the Minister for Planning
On 8 June 2026

RETURN TO WORK ACT 2014

Notice of Day Surgery Facilities

Preamble

The *Scales of Charges for medical practitioners, medical and other charges*, published by the Minister for Industrial Relations in the Government Gazette on 12 June 2026 states that a day surgery facility means *"a facility (other than a private hospital or facility of a private hospital) designed for the provision of medical, surgical or related treatment or care on a same day basis that is declared by the Return to Work Corporation of South Australia by notice in the Gazette to be a day surgery facility".*

NOTICE

In accordance with the power delegated to me by the current *Instrument of Delegation and CEO Financial Authorisations of the Return to Work Corporation of South Australia 12 June 2025*, I, Michael Francis, Chief Executive Officer, declare that each of the following facilities is a day surgery facility for the purposes of the *Scales of Charges for medical practitioners, medical and other charges*, published by the Minister for Industrial Relations in the Government Gazette on 12 June 2026. This list will have effect from 1 July 2026.

Provider ID	Name and Address
0067240H	Adelaide Ambulatory Day Surgery, Suites 10A, 50 Hutt Street, Adelaide 5000
0658181F	Adelaide Day Surgery, 18 North Terrace, Adelaide 5000
0999771L	Adelaide Surgicentre, 89 King William Street, Kent Town 5067
0067310J	Advanced Oral and Maxillofacial Surgery, 238 Angas Street, Adelaide 5000
0067290X	Archer St Day Hospital, 163 Archer Street, North Adelaide 5006
0067120T	Bedford Day Surgery, 913 South Road, Clarence Gardens 5039
0931151B	Brighton Day Surgery, 1 Jetty Road, Brighton 5048
0930971X	Brighton Dialysis Clinic, 361-365 Brighton Road, Hove 5048
0067340B	Burnside Day Surgery, Suite 1, 535-537 Glynburn Road, Hazelwood Park 5066
0065810F	Calvary Connery Centre, 46 John Rice Avenue, Elizabeth Vale 5112
0067220K	Central Day Surgery, 235 Greenhill Road, Dulwich 5065
0067100X	Dextra Surgical, 83 Kensington Road, Norwood 5067
0065960L	GenesisCare Western Hospital, 168 Cudmore Terrace, Henley Beach 5022
0879791H	Glen Osmond Surgicentre, 45 Glen Osmond Road, Eastwood 5063
0657221Y	Glenelg Day Surgery, 24 Gordon Street, Glenelg 5045
0067210L	Greenhill Dental Day Surgery, 62 Greenhill Road, Wayville 5034
0657401W	Hamilton House Day Surgery, 470 Goodwood Road, Cumberland Park 5041
0067320H	Harley Day Surgery, 63 Palmer Place, North Adelaide 5006
0067330F	Hove Day Surgery, 387-389 Brighton Road, Hove 5048
0067150J	Icon Cancer Centre Adelaide, Suite 10, First Floor, Tennyson Centre, 520 South Road, Kurralta Park 5037
0067250F	Icon Cancer Centre Windsor Gardens, Tenancy 1, Level 1, 480 North East Road, Windsor Gardens 5087
0067230J	Lift Cancer Care Services, 7/506-520 South Road, Kurralta Park 5037
0873741Y	North Adelaide Day Surgery Centre, 174 Ward Street, North Adelaide 5006
0834441A	Northern Endoscopy Centre, 127 Frost Road, Salisbury South 5106
0067280Y	Norwood Day Surgery, 42 Nelson Street, Stepney 5069
0067140K	Oromax Day Surgery, Level 2, 66 Rundle Street, Kent Town 5067
0067000A	Parkview Day Surgery, 215 Greenhill Road, Eastwood 5063
0067040T	Payneham Dialysis Clinic, 2 Portrush Road, Payneham 5070
0065970K	PH Prosthodontics SA, 241 Payneham Road, Joslin 5070
0065680Y	Ramsay Day Clinic Kahlyn, 40 Briant Road, Magill 5072
0067080H	Repromed Day Surgery, 180 Fullarton Road, Dulwich 5065
0067260B	Seaford Day Surgery, 4 Vista Parade, Seaford Heights 5169
0067200T	Southern Endoscopy Centre, 271 Brighton Road, Somerton Park 5144
0067130L	The Tennyson Centre Day Hospital, Tenancy 18, Level 1, 520 South Road, Kurralta Park 5037
0067160H	Vista Day Surgery, 57 Greenhill Road, Wayville 5034
0067270A	Windsor Gardens Day Surgery, Suite 1, Level 1, 480 North East Road, Windsor Gardens 5087

Dated: 20 May 2026

MICHAEL FRANCIS
Chief Executive Officer

RETURN TO WORK ACT 2014

Scales of Charges for Medical Practitioners, Medical and Other Charges

Preamble

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

NOTICE

Pursuant to subsection 33(12)(a) of the Act, I publish the following scales of charges to have effect on and from 1 July 2026:

1. scales of charges set out in Schedules 1A and 1B for the provision of medical and related or supplementary services by registered medical practitioners;
2. scales of charges set out in Schedule 2 for the provision of services by chiropractors;
3. scales of charges set out in Schedule 3 for the provision of services by an exercise physiologists (being a class of services which have been authorised by the Corporation under subsection 33(2)(i) of the Act);
4. scales of charges set out in Schedule 4 for the provision of services by occupational therapists;
5. scales of charges set out in Schedule 5 for the provision of services by osteopaths;
6. scales of charges set out in Schedule 6 for the provision of services by physiotherapists;
7. scales of charges set out in Schedule 7 for the provision of services by psychologists;
8. scales of charges set out in Schedule 8 for the provision of services by speech pathologists;
9. scales of charges set out in Schedule 9 for the provision of services by audiologists or audiometrists;
10. scales of charges set out in Schedule 10 for provision of services by accredited mental health social workers (being a class of services which have been authorised by the Corporation under Section 33(2)(i) of the Act);
11. scales of charges set out in Schedule 11 for provision of services by counsellors (being a class of services which have been authorised by the Corporation under Section 33(2)(i) of the Act);
12. scales of charges set out in Schedule 12 for provision of services by mental health occupational therapists;
13. scales of charges set out in Schedule 13 for the provision of services in private hospitals and day surgery facilities.
14. scales of charges for the provision of public hospital compensable patient services, in incorporated hospitals (within the meaning of the *Health Care Act 2008*), being the scale of charges made under the *Health Care Act 2008* as currently in force.
15. In cases of major trauma or a seriously injured worker, the scales of charges in Schedules 2 and 4 to 7 inclusive determined by an hourly rate multiplied by a nominated maximum number of hours, do not apply to the services described therein, with the exception of scale of charges for consultations contained in Schedule 7.

INTERPRETATION

16. In this notice and the Schedules hereto—

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

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

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

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

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

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

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

GST means the tax payable under the GST law;

GST law means—

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

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

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

major trauma includes the following:

- serious orthopaedic injuries with an Abbreviated Injury Severity Score of .3 or above (+/- thoraco/abdominal/pelvic organ trauma .3 or above)
- serious soft tissue trauma requiring major plastic/reconstructive surgery
- serious injuries that lead to an intensive care or high dependency unit hospital stay and/or an inpatient rehabilitation hospital stay

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

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

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

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

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

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

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

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

17. If a charge prescribed in a scale of charges is expressed as an amount per hour—
    (a) a charge is payable for services provided for less than or more than an hour; and
    (b) the amount payable in such circumstances is to be determined by dividing the number of minutes taken to provide the service (rounded to the nearest 6 minutes) by 60, then multiplying by the hourly rate.
18. The scales of charges set out in this notice also apply for the purposes of Section 127A of the *Motor Vehicles Act 1959* subject to modifications specified by that section and modifications specified by any notice in the *Gazette* issued under that section.

GST

19. Where the supply of a service set out in a scale of charges is subject to GST, the maximum fee set out in (or determined as a derived fee in accordance with) the scale of charges in respect of the service is to be increased so that after deduction of the GST in relation to the service the amount of the fee remaining is equal to or less than the maximum fee set out in the scale of charges.
20. Where the maximum fee in respect of a service is determined as a derived fee in accordance with a scale of charges, the fee from which it is derived must not be increased under paragraph 14 to include GST when calculating the derived fee.

Dated: 1 June 2026

HON KYAM MAHERMLC
Minister for Industrial Relations

SCHEDULE 1A

Scale of Charges—Clinical Medical Services

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Item No.	Description	Max Fee (excl. GST)
GROUP A1—GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
	Level A	
00003	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance	$52.90
00004	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients at one place on one occasion-each patient.	$123.60
	Level B	
00023	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation	$113.30
00024	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation an attendance on one or more patients at one place on one occasion each patient	$171.40
	Level C	
00036	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$219.10

Item No.	Description	Max Fee (excl. GST)
00037	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient	$273.80
	Level D	
00044	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$322.80
00047	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient	$377.50
00123	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health related issues, with appropriate documentation	$522.90
00124	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health related issues, with appropriate documentation an attendance on one or more patients at one place on one occasion each patient	$553.30
GROUP A3—SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00104	Professional attendance at consulting rooms or hospital by a specialist in the practice of the specialist's specialty after referral of the patient to the specialist-each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies	$242.30
00105	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist an attendance after the initial attendance in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 126 or 16404 applies	$121.90
00106	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology and following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies)	$219.20
00107	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital	$355.50
00108	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	$225.00
00109	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies)	$546.00
00111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $349.95 or more For any particular patient, once only on the same day	$121.90

Item No.	Description	Max Fee (excl. GST)
00115	Professional attendance at consulting rooms or in hospital on a day by a medical practitioner (the attending practitioner) who is a specialist or consultant physician in the practice of the attending practitioner s specialty after referral of the patient to the attending practitioner by a referring practitioner an attendance after the initial attendance in a single course of treatment, if: (a) the attending practitioner performs a scheduled operation on the patient on the same day; and (b) the operation is a service to which an item in Group T8 applies; and (c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $349.95 or more; and (d) the attendance is unrelated to the scheduled operation; and (e) it is considered a clinical risk to defer the attendance to a later day For any particular patient, once only on the same day	$121.90
00125	Professional attendance lasting at least 45 minutes at consulting rooms or hospital, by a specialist in the practice of the specialist's specialty of gynaecology, following referral of the patient to the specialist by a referring practitioner initial attendance in a single course of treatment, if: (a) the specialist takes a comprehensive history, including psychosocial history and medication review; and (b) the specialist undertakes any of the following that are clinically relevant: (i) a comprehensive multi-system physical examination; (ii) consideration of multiple complex diagnoses; (iii) discussion of all treatment options available; (iv) assessment of pros and cons of each treatment option given patient characteristics and medical history; (v) consideration, discussion and provision of necessary referrals for clinically appropriate investigations or treatment; (vi) communication of a patient-centred management plan; and (c) the specialist makes available to the patient or carer written documentation that outlines treatment options and information on associated risks and benefits; and (d) another attendance on the patient did not take place on the same day by the specialist in the same single course of treatment	$407.40
00126	Professional attendance lasting at least 45 minutes at consulting rooms or hospital, by a specialist in the practice of the specialist's specialty of gynaecology, following referral of the patient to the specialist by a referring practitioner an attendance after the initial attendance in a single course of treatment, if: (a) the specialist takes a comprehensive history, including psychosocial history and medication review; and (b) the specialist reviews implemented management strategies; and (c) the specialist undertakes any of the following that are clinically relevant: (i) update of management plan; (ii) performance of a physical examination; (iii) discussion of treatment options; (iv) consideration, discussion and provision of necessary referrals; (v) provision of appropriate education; and (d) the specialist makes available to the patient or carer written documentation that outlines treatment options and information on associated risks and benefits; and (e) another attendance on the patient did not take place on the same day by the specialist in the same single course of treatment	$203.80
00127	Video attendance lasting at least 45 minutes by a specialist in the practice of the specialist's specialty of gynaecology, following referral of the patient to the specialist by a referring practitioner initial attendance in a single course of treatment, if: (a) the specialist takes a comprehensive history, including psycho-social history and medication review; and (b) the specialist undertakes any of the following that are clinically relevant: (i) arranging for necessary investigations which may include a detailed physical examination; (ii) consideration of multiple complex diagnoses; (iii) discussion of all treatment options available; (iv) assessment of pros and cons of each treatment option given patient characteristics and medical history; (v) consideration, discussion and provision of necessary referrals for clinically appropriate investigations or treatment; (vi) communication of a patient-centred management plan; and (c) the specialist makes available to the patient or carer written documentation that outlines treatment options and information on associated risks and benefits; and (d) an attendance on the patient did not take place on the same day by the same specialist gynaecologist in the same single course of treatment.	$407.40
00129	Video attendance lasting at least 45 minutes by a specialist in the practice of the specialist's speciality of gynaecology, following referral of the patient to the specialist by a referring practitioner - an attendance after the initial attendance in a single course of treatment if: (a) the specialist updates the patient s comprehensive history, including psycho-social history and medication review; and (b) the specialist reviews implemented management strategies; and (c) the specialist undertakes any of the following that are clinically relevant: (i) update of management plan; (ii) arranging for necessary investigations which may include a detailed physical examination; (iii) discussion of treatment options; (iv) consideration, discussion and provision of necessary referrals; (v) provision of appropriate education; and (d) the specialist makes available to the patient or carer written documentation that outlines treatment options and information on associated risks and benefits; and (e) an attendance on the patient did not take place on the same day by the specialist for the same single course of treatment.	$203.80
GROUP A4—CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment	$427.40
00116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 119 applies) after the first in a single course of treatment	$213.80

Item No.	Description	Max Fee (excl. GST)
00117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $349.95 or more For any particular patient, once only on the same day	$213.80
00119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment	$189.30
00120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner minor attendance, if: (a) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the consultant physician subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $349.95 or more For any particular patient, once only on the same day	$189.30
00122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment	$518.40
00128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 131 applies) after the first in a single course of treatment	$313.50
00131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment	$225.80
00132	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; and - comprehensive multi or detailed single organ system assessment; and - 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; and - treatment options and decisions including suggestions to facilitate a return to work; and - medication recommendations; and (c) an attendance on the patient to which item 110, 116, 119, 91824, 91825, 91826, 91836 or 92440 applies did not take place on the same day by the same consultant physician; and (d) a service to which this item or item 92422 applies has not been provided to the patient by the same consultant physician in the preceding 12 months. Note 1: 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.	$747.30
00133	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 20 minutes after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: - review of initial presenting problem/s and results of diagnostic investigations; and - review of responses to treatment and medication plans initiated at time of initial consultation; and - comprehensive multi or detailed single organ system assessment; and - review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner (see Note 2) that involves, where appropriate: - a revised opinion on the diagnosis and risk assessment; and - treatment options and decisions including suggestions to facilitate a return to work; and - revised medication recommendations; and (c) an attendance on the patient to which item 110, 116, 119, 91824, 91825, 91826, 91836 or 92440 applies did not take place on the same day by the same consultant physician; and (d) a service to which item 132 or 92422 applies was provided to the patient by the same consultant physician or a locum tenens in the preceding 12 months; and (e) not more than 2 services to which this item or item 92423 or 92443 applies have been provided to the patient by the same consultant physician or a locum tenens in any 12 month period. Note 1: Should further reviews of the treatment and management plan be required, the appropriate item for such service/s is 116, 91825 or 92440. Note 2: 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.	$374.20

Item No.	Description	Max Fee (excl. GST)
GROUP A28—CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE		
00141	Professional attendance lasting more than 60 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116, 119, 91825 or 92440 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months	$1,281.90
00143	Professional attendance lasting more than 30 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116, 119, 91825 or 92440 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147, 92448 or 92624 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	$801.30
00145	Professional attendance lasting more than 60 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116, 119, 91825 or 92440 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months	$1,554.30
00147	Professional attendance lasting more than 30 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116, 119, 91825 or 92440 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 143, 92448 or 92624 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	$971.50
GROUP A5—PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00160	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	$667.00

Item No.	Description	Max Fee (excl. GST)
00161	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	$1,111.30
00162	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	$1,555.20
00163	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	$2,000.50
00164	Professional attendance by a general practitioner, specialist or consultant physician for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	$2,222.80
GROUP A6—GROUP THERAPY		
00170	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 2 patients	$441.70
00171	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 3 patients	$465.30
00172	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 4 or more patients	$566.10
GROUP A7—ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS		
	Acupuncture	
00193	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$111.50
00195	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, on one or more patients at a hospital, for treatment lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$171.40
00197	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$215.90
00199	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$294.60
	Non-Specialist Practitioner Attendances to which no Other Item Applies	
00179	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area each attendance	$41.50

Item No.	Description	Max Fee (excl. GST)
00181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting not more than 5 minutes an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area each patient	$79.90
00185	Professional attendance at consulting rooms lasting more than 5 minutes but not more than 25 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area each attendance	$90.40
00187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 5 minutes but not more than 25 minutes an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area each patient	$128.90
00189	Professional attendance at consulting rooms lasting more than 25 minutes but not more than 45 minutes (other than a service to which any other applies) by a prescribed medical practitioner in an eligible area each attendance	$175.40
00191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 25 minutes but not more than 45 minutes an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area each patient	$213.80
00203	Professional attendance at consulting rooms lasting more than 45 minutes but not more than 60 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area each attendance	$258.20
00206	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 45 minutes but not more than 60 minutes an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area each patient	$296.70
00301	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item in this Schedule applies) by a prescribed medical practitioner in an eligible area each attendance	$418.30
00303	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 60 minutes an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area each patient	$305.00
	Non-Specialist Practitioner Prolonged Attendances to which no Other Item Applies	
00214	Professional attendance by a prescribed medical practitioner for a period of not less than one hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	$533.60
00215	Professional attendance by a prescribed medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	$889.20
00218	Professional attendance by a prescribed medical practitioner for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	$1,244.10
00219	Professional attendance by a prescribed medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	$1,600.60
00220	Professional attendance by a prescribed medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	$1,778.30
	Non-Specialist Practitioner Group Therapy	
00221	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family each Group of 2 patients	$282.90
00222	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family each Group of 3 patients	$298.30
00223	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family each Group of 4 or more patients	$363.00
	Non-Specialist Practitioner Health Assessments	
00177	Professional attendance on a patient who is 30 years of age or over for a heart health assessment by a prescribed medical practitioner at consulting rooms lasting at least 20 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination, which must include recording blood pressure and cholesterol; and (c) initiating interventions and referrals as indicated; and (d) implementing a management plan; and (e) providing the patient with preventative health care advice and information.	$175.40
00224	Professional attendance by a prescribed medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	$143.00

Item No.	Description	Max Fee (excl. GST)
00225	Professional attendance by a prescribed medical practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	$332.10
00226	Professional attendance by a prescribed medical practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient s medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	$458.20
00227	Professional attendance by a prescribed medical practitioner to perform a prolonged health assessment, lasting at least 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient s medical condition, and physical, psychological and social function; and (c) initiating interventions and referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient	$647.40
00228	Professional attendance by a prescribed medical practitioner at consulting rooms or in a place other than a hospital or a residential aged care facility: (a) for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent; and (b) that includes the following: (i) recognising the patient s health priorities; (ii) taking the patient s medical history; (iii) undertaking any relevant physical examinations; (iv) undertaking or arranging any required investigations; (v) assessing the patient using the information gained in the health assessment; (vi) initiating any necessary interventions and referrals; (vii) developing and documenting a plan to manage the patient s health, including for follow up, based on the health assessment and the patient s priorities; (viii) offering the patient (or the patient s carer (if any) if the practitioner considers it appropriate and the patient agrees) a written report of the health assessment, with recommendations on matters covered by the health assessment and a strategy for the patient s good health; (ix) if the offer referred to in subparagraph (viii) is accepted giving the report to the patient or the patient s carer (as applicable); (x) adding a record of the health assessment to the patient s medical records Applicable only if a service to which this item or item 715, 92004 or 92011 applies has not been provided to the patient in the preceding 9 months Note: For items 92004 and 92011, see the Telehealth Attendance Determination.	$511.20
	Non-Specialist Practitioner Management Plans, Team Care Arrangements and Multidisciplinary Care Plans and Case Conferences	
00231	Either: (a) contribution to a multidisciplinary care plan, for a patient, prepared by another provider; or (b) contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider;by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240, 735, 739, 743, 747, 750 or 758 apply	$169.50
00232	Either: (a) contribution to a multidisciplinary care plan, for a patient in a residential aged care facility, prepared by that facility, or contribution to a review of a multidisciplinary care plan, for a patient, prepared by such a facility; or (b) contribution to a multidisciplinary care plan, for a patient, prepared by another provider before the patient is discharged from a hospital or contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider;by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240, 735, 739, 743, 747, 750 or 758 apply	$169.50
00392	Professional attendance by a prescribed medical practitioner to prepare a GP chronic condition management plan for a patient	$333.80
00393	Professional attendance by a prescribed medical practitioner to review a GP chronic condition management plan prepared by the prescribed medical practitioner or an associated medical practitioner	$308.20
	Non-Specialist Practitioner Domiciliary and Residential Medication Management Review	
00245	Participation by a prescribed medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the prescribed medical practitioner, with the patient s consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having the patient s therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patientFor any particular patient applicable not more than once in each 12 month period, and only if item 900 does not apply in the same 12 month period, except if there has been a significant change in the patient s condition or medication regimen requiring a new DMMR	$372.90
00249	Participation by a prescribed medical practitioner in a residential medication management review (RMMR) for a patient who is a care recipient in a residential aged care facility other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident s medical condition or medication management plan requiring a new RMMR	$255.20
	Non-Specialist Practitioner Mental Health Care	
00272	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	$172.70

Item No.	Description	Max Fee (excl. GST)
00276	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient	$254.20
00281	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	$219.20
00282	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient	$323.10
00283	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes	$223.40
00285	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes	$261.90
00286	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes	$319.70
00287	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes	$358.10
00309	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes	$223.40
00311	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes	$190.90
00313	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$319.70
00315	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$255.10
	Non-Specialist Practitioner After-Hours Attendances to which no Other Item Applies	
00733	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner each attendance	$69.80
00737	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner each attendance	$117.80
00741	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner each attendance	$202.40
00745	Professional attendance at consulting rooms of more than 45 minutes in duration but not more than 60 minutes (other than a service to which another item applies) by a prescribed medical practitioner each attendance	$283.80
00761	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes an attendance on one or more patients on one occasion each patient	$108.30
00763	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes an attendance on one or more patients on one occasion each patient	$156.20
00766	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes an attendance on one or more patients on one occasion each patient	$240.70

Item No.	Description	Max Fee (excl. GST)
00769	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes an attendance on one or more patients on one occasion each patient	$322.10
00772	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a prescribed medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$139.00
00776	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a prescribed medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$187.00
00788	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a prescribed medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$271.50
00789	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 45 minutes but not more than 60 minutes in duration by a prescribed medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$352.90
02197	Professional attendance at consulting rooms of more than 60 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner each attendance.	$603.00
	Non-Specialist Practitioner Pregnancy Support Counselling	
00792	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, lasting at least 20 minutes, for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item, or item 4001, 81000, 81005, 81010, 92136, 92137, 92138, 92139, 93026 or 93029, applies in relation to that pregnancy	$204.30
	Prescribed Medical Practitioner Patient End Support for Video Conferencing Consultations with Specialist	
00373	Professional attendance by a prescribed medical practitioner, at consulting rooms, lasting more than 5 minutes but not more than 25 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$135.40
00374	Professional attendance by a prescribed medical practitioner, at a place other than consulting rooms, lasting more than 5 minutes but not more than 25 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$195.90
00375	Professional attendance by a prescribed medical practitioner, at a residential aged care facility, lasting more than 5 minutes but not more than 25 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$135.40
00376	Professional attendance by a prescribed medical practitioner, at consulting rooms, lasting more than 25 minutes but not more than 45 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$216.40
00377	Professional attendance by a prescribed medical practitioner, at a place other than consulting rooms, lasting more than 25 minutes but not more than 45 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$246.60

Item No.	Description	Max Fee (excl. GST)
00378	Professional attendance by a prescribed medical practitioner, at a residential aged care facility, lasting more than 25 minutes but not more than 45 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$216.40
00379	Professional attendance by a prescribed medical practitioner, at consulting rooms, lasting more than 45 minutes but not more than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$295.30
00380	Professional attendance by a prescribed medical practitioner, at a place other than consulting rooms, lasting more than 45 minutes but not more than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$355.80
00381	Professional attendance by a prescribed medical practitioner, at a residential aged care facility, lasting more than 45 minutes but not more than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$295.30
00382	Professional attendance by a prescribed medical practitioner, at consulting rooms, lasting more than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$448.00
00390	Professional attendance by a prescribed medical practitioner, at a place other than consulting rooms, lasting more than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$508.50
00391	Professional attendance by a prescribed medical practitioner, at a residential aged care facility, lasting more than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance	$448.00
GROUP A8—CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00289	Professional attendance lasting at least 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 92140, 92141, 92142 or 92434) Applicable only once per lifetime	$747.30
00291	Professional attendance lasting more than 45 minutes at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner, for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months that comprehensively evaluates the patient s biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 92435 applies has not been provided to the patient	$1,281.90

Item No.	Description	Max Fee (excl. GST)
00293	Professional attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or item 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the revised comprehensive diagnostic assessment of the patient; and (ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 or item 92435 applies has been provided to the patient; and (g) in the preceding 12 months, a service to which this item or item 92436 or 92444 applies has not been provided to the patient	$801.30
00296	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance at consulting rooms if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 92437 and 92478 to 92483 has applied in the preceding 24 months	$737.30
00297	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance at hospital if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item, or any of items 296, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 92437 and 92478 to 92483 has applied in the preceding 24 months (H)	$737.30
00299	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner - an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item, or any of items 296, 297, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 92437 and 92478 to 92483 has applied in the preceding 24 months	$881.50
00300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	$122.70
00302	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	$244.90
00304	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	$376.90
00306	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 45 minutes, but not more than 75 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	$520.20
00308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	$603.70

Item No.	Description	Max Fee (excl. GST)
00310	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	$113.60
00312	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	$229.20
00314	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	$338.80
00316	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 45 minutes, but not more than 75 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	$513.30
00318	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	$573.10
00319	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 45 minutes at consulting rooms, if: (a) the formulation of the patient s clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment; and (b) that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91873 and 92437 applies have not exceeded 160 attendances in a calendar year for the patient	$520.20
00320	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting not more than 15 minutes at hospital (H)	$122.70
00322	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 15 minutes, but not more than 30 minutes, at hospital (H)	$244.90
00324	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 30 minutes, but not more than 45 minutes, at hospital (H)	$376.90
00326	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 45 minutes, but not more than 75 minutes, at hospital (H)	$520.20
00328	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 75 minutes at hospital (H)	$603.70
00330	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting not more than 15 minutes if that attendance is at a place other than consulting rooms or hospital	$225.30
00332	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 15 minutes, but not more than 30 minutes, if that attendance is at a place other than consulting rooms or hospital	$352.80
00334	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 30 minutes, but not more than 45 minutes, if that attendance is at a place other than consulting rooms or hospital	$514.20
00336	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 45 minutes, but not more than 75 minutes, if that attendance is at a place other than consulting rooms or hospital	$622.20
00338	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance lasting more than 75 minutes if that attendance is at a place other than consulting rooms or hospital	$706.70

Item No.	Description	Max Fee (excl. GST)
00341	An interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	$122.70
00342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient	$141.50
00343	An interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	$244.90
00344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient	$185.30
00345	An interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	$376.90
00346	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient	$274.20
00347	An interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	$520.20
00349	An interview, lasting more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 347, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	$603.70
GROUP A12—CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-initial attendance in a single course of treatment	$413.60
00386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-each attendance after the first in a single course of treatment	$189.30
00387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-initial attendance in a single course of treatment	$488.30
00388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-each attendance after the first in a single course of treatment	$264.10

Item No.	Description	Max Fee (excl. GST)
GROUP A13—PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
	Level A	
00410	Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.	$55.40
	Level B	
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, including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$121.10
	Level C	
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, including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$234.20
	Level D	
00413	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 40 minutes, including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$344.90
GROUP A21—PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS		
	Consultations	
05001	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision making of ordinary complexity	$166.60
05011	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	$279.80
05012	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	$438.40
05014	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	$551.60
05016	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	$740.20
05019	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	$853.50
05021	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	$165.20
05027	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	$277.60
05030	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	$434.90
05032	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	$547.50
05033	Professional attendance, on a patient 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	$734.60

Item No.	Description	Max Fee (excl. GST)
05036	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	$847.20
	Prolonged Professional Attendances	
05039	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019	$404.50
05041	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (d) the attendance is for at least 60 minutes	$760.40
05042	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036	$378.70
05044	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (d) the attendance is for at least 60 minutes	$712.60
GROUP A11—URGENT ATTENDANCE AFTER HOURS		
	After Hours	
00585	Professional attendance by a general practitioner on one patient on one occasion each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$390.90
00588	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$362.20
00591	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$251.10
00594	Professional attendance by a medical practitioner each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient	$126.30
00599	Professional attendance by a general practitioner on not more than one patient on one occasion each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$588.00
00600	Professional attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$368.10

Item No.	Description	Max Fee (excl. GST)
GROUP A14—HEALTH ASSESSMENTS		
00699	Professional attendance on a patient who is 30 years of age or over for a heart health assessment by a general practitioner at consulting rooms lasting at least 20 minutes and including: collection of relevant information, including taking a patient history; and a basic physical examination, which must include recording blood pressure and cholesterol; and initiating interventions and referrals as indicated; and implementing a management plan; and providing the patient with preventative health care advice and information.	$219.10
00701	Professional attendance by a general practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	$181.40
00703	Professional attendance by a general practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	$415.10
00705	Professional attendance by a general practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	$572.90
00707	Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient	$809.30
00715	Professional attendance by a general practitioner, at consulting rooms or in a place other than a hospital or a residential aged care facility: (a) for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent; and (b) that includes the following: (i) recognising the patient s health priorities; (ii) taking the patient s medical history; (iii) undertaking any relevant physical examinations; (iv) undertaking or arranging any required investigations; (v) assessing the patient using the information gained in the health assessment; (vi) initiating any necessary interventions and referrals; (vii) developing and documenting a plan to manage the patient s health, including for follow up, based on the health assessment and the patient s priorities; (viii) offering the patient (or the patient s carer (if any) if the practitioner considers it appropriate and the patient agrees) a written report of the health assessment, with recommendations on matters covered by the health assessment and a strategy for the patient s good health; (ix) if the offer referred to in subparagraph (viii) is accepted giving the report to the patient or the patient s carer (as applicable); (x) adding a record of the health assessment to the patient s medical records Applicable only if a service to which this item or item 228, 92004 or 92011 applies has not been provided to the patient in the preceding 9 months Note: For items 92004 and 92011, see the Telehealth Attendance Determination.	$639.10
GROUP A15—GP MANAGEMENT PLANS TEAM CARE ARRANGEMENTS MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES		
00965	Professional attendance by a general practitioner to prepare a GP chronic condition management plan for a patient	$385.10
00967	Professional attendance by a general practitioner to review a GP chronic condition management plan prepared by the general practitioner or an associated medical practitioner	$385.10
GROUP A17—DOMICILIARY MEDICATION MANAGEMENT REVIEW		
00900	Participation by a general practitioner (not including a specialist or consultant physician) in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the general practitioner, with the patient s consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patientFor any particular patient applicable not more than once in each 12 month period, and only if item 245 does not apply in the same 12 month period, except if there has been a significant change in the patient s condition or medication regimen requiring a new DMMR	$581.80
00903	Participation by a general practitioner (not including a specialist or consultant physician) in a residential medication management review (RMMR) for a patient who is a care recipient in a residential aged care facility other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 249 has applied, unless there has been a significant change in the resident s medical condition or medication management plan requiring a new RMMR.	$473.40

Item No.	Description	Max Fee (excl. GST)
GROUP A20—GP MENTAL HEALTH TREATMENT		
	GP Mental Health Care Plans	
02700	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$274.10
02701	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$408.60
02715	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$342.00
02717	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$503.80
	Focussed Psychological Strategies	
02721	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	$348.50
02723	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	$406.00
02725	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	$498.70
02727	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	$556.20
02739	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes, but less than 40 minutes	$348.50
02741	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes, but less than 40 minutes	$238.60
02743	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$498.70
02745	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$319.00
GROUP A24—PAIN AND PALLIATIVE MEDICINE		
	Pain Medicine Attendances	
02801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$427.40
02806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment	$213.80

Item No.	Description	Max Fee (excl. GST)
02814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$189.30
02824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$518.40
02832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2840 applies) after the first in a single course of treatment	$313.50
02840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$264.10
	Pain Medicine Case Conferences	
02978	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$393.80
02984	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$591.10
02988	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	$787.50
02992	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$282.80
02996	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$451.20
03000	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	$619.40
	Palliative Medicine Attendances	
03005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$427.40
03010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment	$213.80
03014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$264.10
03018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$518.40
03023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment	$313.50

Item No.	Description	Max Fee (excl. GST)
03028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$264.10
	Palliative Medicine Case Conferences	
03032	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	$393.80
03069	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$393.80
03074	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$591.10
03078	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	$787.50
03083	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$282.80
03088	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$451.20
03093	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	$619.40
GROUP A27—PREGNANCY SUPPORT COUNSELLING		
04001	Professional attendance of at least 20 minutes in duration at consulting rooms by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a patient who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy	$213.70
GROUP A22—GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
05000	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance	$87.20
05003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies) that requires a short patient history and, if necessary, limited examination and management an attendance on one or more patients on one occasion each patient	$149.50
05010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on one or more patients at one residential aged care facility on one occasion each patient	$185.30
05020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation	$149.50

Item No.	Description	Max Fee (excl. GST)
05023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation an attendance on one or more patients on one occasion each patient	$219.20
05028	Professional attendance by a general practitioner (other than a service to which another item in this Schedule applies), on care recipients in a residential aged care facility, lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$245.60
05040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$269.10
05043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient	$338.80
05049	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$350.90
05060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$418.60
05063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient	$493.30
05067	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$493.30
05071	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation	$603.00
GROUP A26—NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
06007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital	$373.30
06009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-a minor attendance after the first in a single course of treatment at consulting rooms or hospital	$124.00
06011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital	$246.50

Item No.	Description	Max Fee (excl. GST)
06013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital	$341.60
06015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital	$434.90
GROUP A31—ADDICTION MEDICINE		
	Addiction Medicine Attendances	
06018	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	$488.30
06019	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment	$264.10
06023	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018, 6019, 91825, 92422, 92423, 92440 or 92443 applies did not take place on the same day by the same addiction medicine specialist; and (d) a service to which this item or item 132 applies has not been provided to the patient by the same addiction medicine specialist in the preceding 12 months	$760.40
06024	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018, 6019, 91825, 92422, 92423, 92440 or 92443 applies did not take place on the same day by the same addiction medicine specialist; and (d) a service to which item 6023 applies was provided to the patient by the same addiction medicine specialist or a locum tenens in the preceding 12 months; and (e) not more than 2 services to which this item applies have been provided to the patient by the same addiction medicine specialist or a locum tenens in any 12 month period	$380.80
	Group Therapy	
06028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of the addiction medicine specialist's specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner-for each patient	$142.00
GROUP A32—SEXUAL HEALTH MEDICINE		
	Sexual Health Medicine Attendances	
06051	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	$427.40
06052	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment	$213.80

Item No.	Description	Max Fee (excl. GST)
06057	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051, 6052, 91825, 92422, 92423, 92440 or 92443 applies did not take place on the same day by the same sexual health medicine specialist; and (d) a service to which this item or item 132 applies has not been provided to the patient by the same sexual health medicine specialist in the preceding 12 months	$747.30
06058	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051, 6052, 91825, 92422, 92423, 92440 or 92443 applies did not take place on the same day by the same sexual health medicine specialist; and (d) a service to which item 6057 applies was provided to the patient by the same sexual health medicine specialist or a locum tenens in the preceding 12 months; and (e) not more than 2 services to which this item applies have been provided to the patient by the same sexual health medicine specialist or a locum tenens in any 12 month period	$374.20
	Home Visits	
06062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-initial attendance in a single course of treatment	$518.40
06063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-each attendance after the attendance under item 6062 in a single course of treatment	$313.50
GROUP A37—CARDIOTHORACIC SURGEON ATTENDENCE FOR LEAD EXTRACTION		
90300	Professional attendance by a cardiothoracic surgeon in the practice of the surgeon s speciality, if: (a) the service is: performed in conjunction with a service (the lead extraction service) to which item 38358 applies; or performed in conjunction with a service (the leadless pacemaker extraction service) to which item 38373 or 38374 applies; or performed in conjunction with a service (the TAVI intermediate or low surgical risk service) to which item 38514 or 38522 applies); and (b) the surgeon: is providing surgical backup for the provider (who is not a cardiothoracic surgeon) who is performing the lead extraction service, the leadless pacemaker extraction service or the TAVI intermediate or low surgical risk service; and is present for the duration of the lead extraction service, the leadless pacemaker extraction service or the TAVI intermediate or low surgical risk service, other than during the low risk pre and post extraction or transcatheter aortic valve implantation phases; and is able to immediately scrub in and perform a thoracotomy if Major Complications occur (H)	$2,551.20
GROUP A40—TELEHEALTH AND PHONE ATTENDANCE SERVICES		
	General Practice Telehealth Services	
91790	Video attendance by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$52.90
91792	Video attendance by a medical practitioner (not including a general practitioner) of not more than 5 minutes NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$59.30
91794	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 minutes NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$86.90
91800	Video attendance by a general practitioner lasting at least 6 minutes but less than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$113.30

Item No.	Description	Max Fee (excl. GST)
91801	Video attendance by a general practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$219.10
91802	Video attendance by a general practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$322.80
91803	Video attendance by a medical practitioner (not including a general practitioner) of more than 5 minutes in duration but not more than 25 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$113.20
91804	Video attendance by a medical practitioner (not including a general practitioner) of more than 25 minutes in duration but not more than 45 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$204.90
91805	Video attendance by a medical practitioner (not including a general practitioner) of more than 45 minutes in duration but not more than 60 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$328.90
91806	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 5 minutes in duration but not more than 25 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$189.00
91807	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 25 minutes in duration but not more than 45 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$366.40
91808	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 45 minutes in duration but not more than 60 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$539.50
91920	Video attendance by a general practitioner, lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$522.90
91923	Video attendance by a medical practitioner (not including a general practitioner), of more than 60 minutes in duration and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$530.60
91926	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 60 minutes in duration and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$874.00

Item No.	Description	Max Fee (excl. GST)
	General Practice Phone Services	
91890	Phone attendance by a general practitioner lasting less than 6 minutes for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$52.90
91891	Phone attendance by a general practitioner lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$113.30
91892	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting less than 6 minutes for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$59.30
91893	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$113.20
	Focssed Psychological Strategies Telehealth Services	
91818	Video attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes.	$308.90
91819	Video attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes	$433.60
91820	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes	$466.90
91821	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes	$668.00
91859	Video attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes	$279.20
91861	Video attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$399.60
91862	Video attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes	$466.70
91863	Video attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$668.00
	Specialist Attendances Telehealth Services	
91822	Video attendance for a person by a specialist in the practice of the specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance was other than a second or subsequent attendance as part of a single course of treatment	$242.30
91823	Video attendance for a person by a specialist in the practice of the specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is after the first attendance as part of a single course of treatment	$121.90

Item No.	Description	Max Fee (excl. GST)
	Consultant Physician Telehealth Services	
91824	Video attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the consultant physician; and (b) the attendance was of more than 5 minutes in duration; Where the attendance was other than a second or subsequent attendance as part of a single course of treatment	$427.40
91825	Video attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the consultant physician; and (b) the attendance was of more than 5 minutes in duration; Where the attendance is not a minor attendance after the first as part of a single course of treatment	$213.80
91826	Video attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the consultant physician; and (b) the attendance was of more than 5 minutes in duration; Where the attendance is a minor attendance after the first as part of a single course of treatment	$122.70
92422	Video attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 of the general medical services table or item 91824, 91825, 91826, 91836 or 92440 applies did not take place on the same day by the same consultant physician; and (d) this item, or item 132 of the general medical services table, has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician	$747.30
92423	Video attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 20 minutes in duration after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 of the general medical services table or item 91824, 91825, 91826, 91836 or 92440 applies did not take place on the same day by the same consultant physician; and (d) item 132 of the general medical services table or item 92422 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 of the general medical services table or item 92422; and (f) this item, or item 133 of the general medical services table or item 92443 has not applied more than twice in any 12 month period	$374.20
	Consultant Psychiatrist Telehealth Services	
91827	Video attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was not more than 15 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91828 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$122.70
91828	Video attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 15 minutes, but not more than 30 minutes in duration; if that attendance and another attendance to which item 296, 297, 299, or any of items 300, 302, 304, 306 to 308, 91827, 91829 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$244.90
91829	Video attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 30 minutes, but not more than 45 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827, 91828, 91830, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$376.90
91830	Video attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 45 minutes, but not more than 75 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91829, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$520.20
91831	Video attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 75 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91830, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$603.70

Item No.	Description	Max Fee (excl. GST)
91868	Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of not more than 15 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91869, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient	$100.00
91869	Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of more than 15 minutes but not more than 30 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient	$200.70
91870	Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of more than 30 minutes but not more than 45 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient	$309.10
91871	Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of more than 45 minutes but not more than 75 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient	$425.90
91872	Video attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of more than 75 minutes in duration, if that attendance and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91873, or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient	$493.80
91873	Video attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the psychiatrist by a referring practitioner, where the formulation of the patient s clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment, if that attendance and another attendance to which any of items 296, 297, 299 or any of items 300, 302, 304, 306, 308, 319, 92437, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91872 or 91879 to 91881 applies has not exceeded 160 attendances in a calendar year for the patient	$851.10
91874	Video attendance involving an interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91875, 91876, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient	$200.70
91875	Video attendance involving an interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91876, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient	$400.70
91876	Video attendance involving an interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient	$616.60
91877	Video attendance involving an interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91876 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient	$851.10
91878	Video attendance involving an interview, lasting more than 75 minutes, of a person other than the patient, when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91876, 91877, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient	$987.60

Item No.	Description	Max Fee (excl. GST)
92434	Video attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 289, 92140, 92141 or 92142) Applicable only once per lifetime	$747.30
92435	Video attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant and (d) within 2 weeks after the attendance, the consultant prepares and gives the referring practitioner a written report, which includes: (i) a comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months for the patient that comprehensively evaluates the patient s biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and a gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 291 of the general medical services table applies has not been provided	$1,281.90
92436	Video attendance lasting more than 30 minutes, but not more than 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) a revised comprehensive diagnostic assessment of the patient; and (ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and the management plan, and gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 of the general medical services table or item 92435 applies has been provided; and (g) in the preceding 12 months, a service to which this item or item 293 of the general medical services table or item 92444 applies has not been provided	$801.30
92437	Video attendance of more than 45 minutes in duration by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner: (a) if the patient: (i) is a new patient for this consultant physician; or (ii) has not received an attendance from this consultant physician in the preceding 24 months; and (b) the patient has not received an attendance under this item, or item 91827 to 91831, 91837 to 91839, 92455 to 92457, 91868 to 91873, 91879 to 91881 or item 296, 297, 299, 300, 302, 304, 306 to 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344 or 346 of the general medical services table, in the preceding 24 months	$737.30
92455	Video attendance for group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry; and (c) involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner; each patient	$141.50
92456	Video attendance for group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry; and (c) involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner; each patient	$185.30
92457	Video attendance for group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry; and (c) involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner; each patient	$274.20

Item No.	Description	Max Fee (excl. GST)
92478	Video attendance for an admitted patient by a consultant psychiatrist; if: (a) the attendance follows referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the patient is located at a hospital; and (c) the attendance is not more than 15 minutes duration; and (d) the patient has not received a service to which this item or item 92479, 92480, 92481, 92482 or 92483 applies in the last seven days (H)	$118.00
92479	Video attendance for an admitted patient by a consultant psychiatrist; if: (a) the attendance follows referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the patient is located at a hospital; and (c) the attendance is at least 15 minutes, but not more than 30 minutes in duration; and (d) the patient has not received a service to which this item or item 92478, 92480, 92481, 92482 or 92483 applies in the last seven days (H)	$235.50
92480	Video attendance for an admitted patient by a consultant psychiatrist; if: (a) the attendance follows referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the patient is located at a hospital; and (c) the attendance was at least 30 minutes, but not more than 45 minutes in duration; and (d) the patient has not received a service to which this item or item 92478, 92479, 92481, 92482 or 92483 applies in the last seven days (H)	$362.50
92481	Video attendance for an admitted patient by a consultant psychiatrist; if: (a) the attendance follows referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the patient is located at a hospital; and (c) the attendance was at least 45 minutes, but not more than 75 minutes in duration; and (d) the patient has not received a service to which this item or item 92478, 92479, 92480, 92482 or 92483 applies in the last seven days (H)	$500.30
92482	Video attendance for an admitted patient by a consultant psychiatrist; if: (a) the attendance follows referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the patient is located at a hospital; and (c) the attendance was at least 75 minutes in duration; and (d) the patient has not received a service to which this item or item 92478, 92479, 92480, 92481 or 92483 applies in the last seven days (H)	$580.50
92483	Video attendance of more than 45 minutes by a consultant psychiatrist following referral of the patient to the consultant psychiatrist by a referring practitioner an attendance on a patient located at a hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from the consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, or any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 92437 and 92478 to 92482 has applied in the preceding 24 months (H)	$709.10
	Specialist Attendances Phone Services	
91833	Phone attendance for a person by a specialist in the practice of the specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is after the first attendance as part of a single course of treatment.	$121.90
	Consultant Physician Phone Services	
91836	Phone attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the consultant physician; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is a minor attendance after the first as part of a single course of treatment.	$189.30
92440	Phone attendance for a person by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the consultant physician; and (b) the attendance was of more than 5 minutes in duration; where the attendance is after the first attendance as part of a single course of treatment	$213.80
92443	Phone attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 20 minutes in duration after the first attendance in a single course of treatment for a review of a patient with at least two morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 of the general medical services table or item 91824, 91825, 91826, 91836 or 92440 applies did not take place on the same day by the same consultant physician; and (d) item 132 of the general medical services table or item 92422 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 of the general medical services table or item 92422; and (f) this item, or item 133 of the general medical services table or item 92423 has not applied more than twice in any 12 month period	$374.20
	Consultant Psychiatrist Phone Services	
91837	Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was not more than 15 minutes duration; Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91838, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$122.70

Item No.	Description	Max Fee (excl. GST)
91838	Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner and (b) the attendance was at least 15 minutes, but not more than 30 minutes in duration; Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year	$244.90
91839	Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 30 minutes, but not more than 45 minutes in duration Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91838 and 92437 applies have not exceeded 50 attendances in a calendar year	$376.90
91879	Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of not more than 15 minutes in duration, if that attendance and another attendance to which 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91880, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient	$100.00
91880	Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of more than 15 minutes but not more than 30 minutes in duration, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient	$200.70
91881	Phone attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner an attendance of more than 30 minutes but not more than 45 minutes in duration, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91880 or 92437 applies exceed 50 attendances in a calendar year for the patient	$309.10
91882	Phone attendance involving an interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient	$200.70
91883	Phone attendance involving an interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91882 or 91884 applies have not exceeded 15 in a calendar year for the patient	$400.70
91884	Phone attendance involving an interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91882 or 91883 applies have not exceeded 15 in a calendar year for the patient	$616.60
92444	Phone attendance lasting more than 30 minutes, but not more than 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) a revised comprehensive diagnostic assessment of the patient; and (ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient's ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and the management plan, and gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 of the general medical services table or item 92435 applies has been provided; and (g) in the preceding 12 months, a service to which this item or item 293 of the general medical services table or item 92436 applies has not been provided	$801.30

Item No.	Description	Max Fee (excl. GST)
	Focussed Psychological Strategies Phone Services	
91842	Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes.	$308.90
91843	Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes.	$433.60
91844	Phone attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes	$466.90
91845	Phone attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes	$668.00
91864	Phone attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes	$279.20
91865	Phone attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$399.60
91866	Phone attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes	$466.70
91867	Phone attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes	$668.00
	Health Assessment for Aboriginal and Torres Strait Islander People—Telehealth Service	
92004	Video attendance by a general practitioner for an Aboriginal and Torres Strait Islander health assessment: (a) for a patient who is of Aboriginal or Torres Strait Islander descent; and (b) that includes the following: (i) recognising the patient s health priorities; (ii) taking the patient s medical history; (iii) undertaking any relevant physical examinations; (iv) undertaking or arranging any required investigations; (v) assessing the patient using the information gained in the health assessment; (vi) initiating any necessary interventions and referrals; (vii) developing and documenting a plan to manage the patient s health including for follow-up, based on the health assessment and the patient s priorities; (viii) offering the patient (or the patient s carer (if any) if the practitioner considers it appropriate and the patient agrees) a written report of the health assessment, with recommendations on matters covered by the health assessment and a strategy for the patient s good health; (ix) if the offer referred to in subparagraph (viii) is accepted giving the report to the patient or the patient s carer (as applicable); (x) adding a record of the health assessment to the patient s medical recordsApplicable only if a service to which this item or item 228, 715 or 92011 applies has not been provided to the patient in the preceding 9 months	$639.10
92011	Video attendance by a prescribed medical practitioner for an Aboriginal and Torres Strait Islander health assessment: (a) for a patient who is of Aboriginal or Torres Strait Islander descent; and (b) that includes the following: (i) recognising the patient s health priorities; (ii) taking the patient s medical history; (iii) undertaking any relevant physical examinations; (iv) undertaking or arranging any required investigations; (v) assessing the patient using the information gained in the health assessment; (vi) initiating any necessary interventions and referrals; (vii) developing and documenting a plan to manage the patient s health including for follow-up, based on the health assessment and the patient s priorities; (viii) offering the patient (or the patient s carer (if any) if the practitioner considers it appropriate and the patient agrees) a written report of the health assessment, with recommendations on matters covered by the health assessment and a strategy for the patient s good health; (ix) if the offer referred to in subparagraph (viii) is accepted giving the report to the patient or the patient s carer (as applicable); (x) adding a record of the health assessment to the patient s medical recordsApplicable only if a service to which this item or item 228, 715 or 92004 applies has not been provided to the patient in the preceding 9 months	$1,068.10

Item No.	Description	Max Fee (excl. GST)
	Chronic Disease Management(CDM) Service—Telehealth Service	
92029	Video attendance by a general practitioner to prepare a GP chronic condition management plan for a patient	$385.10
92030	Video attendance by a general practitioner to review a GP chronic condition management plan prepared by the general practitioner or an associated medical practitioner	$385.10
92057	Contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician) by video to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$354.20
92058	Contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician) by video to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s eligible telehealth practitioner (please see Note AN.1.1 for the definitions as some exemptions do apply)	$354.20
92060	Video attendance by a prescribed medical practitioner to prepare a GP chronic condition management plan for a patient	$333.80
92061	Video attendance by a prescribed medical practitioner to review a GP chronic condition management plan prepared by the prescribed medical practitioner or an associated medical practitioner	$308.20
	GP Mental Health Treatment Plan—Telehealth Service	
92112	Video attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$274.10
92113	Video attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$318.90
92116	Video attendance, by a general practitioner who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$274.10
92117	Video attendance, by a general practitioner who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$403.80
92118	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$360.80
92119	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$531.10
92122	Video attendance by a medical practitioner, (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$458.00
92123	Video attendance by a medical practitioner, (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$675.00
	GP and Other Medical Practitioner—Urgent Hours Serviec in Unsociable Hours—Telehealth Service	
92210	Video attendance by a general practitioner on not more than one patient on one occasion each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after hours period; and (b) the patient s medical condition requires urgent assessment	$588.00
92211	Video attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after hours period; and (b) the patient s medical condition requires urgent assessment	$769.10

Item No.	Description	Max Fee (excl. GST)
	Public health physician—Telehealth Services	
92513	Video attendance by a public health physician in the practice of the public health physician's specialty of public health medicine attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management	$55.40
92514	Video attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation	$121.10
92515	Video attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation	$234.20
92516	Video attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation	$344.90
	Public health physician—Phone Services	
92521	Phone attendance by a public health physician in the practice of the public health physician's specialty of public health medicine attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management; Where the attendance is not the first attendance for that particular clinical indication	$55.40
92522	Phone attendance by a public health physician in the practice of the public health physician's specialty of public health medicine, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, where the attendance is not the first attendance for those particular health related issues, with appropriate documentation	$121.10
	Neurosurgery attendances—Telehealth Services	
92610	Video attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist (other than a second or subsequent attendance in a single course of treatment)	$373.30
92611	Video attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist a minor attendance after the first in a single course of treatment	$124.00
92612	Video attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration	$246.50
92613	Video attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration	$341.60
92614	Video attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration	$434.90
	Neurosurgery attendances—Phone Services	
92445	Phone attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration	$246.50
92446	Phone attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration	$341.60
92447	Phone attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist an attendance after the first in a single course of treatment, involving arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration	$434.90
92618	Phone attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist a minor attendance after the first in a single course of treatment.	$124.00

Item No.	Description	Max Fee (excl. GST)
	Specialist, anaesthesia—Telehealth Services	
92701	Video attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and the formulation of a written patient management plan documented in the patient notes, and lasting more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 of the general medical services table apply)	$349.30
	Specialist and Consultant Physician—Telehealth Services	
92748	Video attendance for a person by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine if: (a) the attendance follows referral of the patient to the consultant occupational physician (b) the attendance is of more than 5 minutes in duration; (c) the attendance is an initial attendance in a single course of treatment; and (d) the attendance on the patient, being an attendance to which item 385, 91822, or 104 applies did not take place on the same day by the same consultant occupational physician.	$413.60
92749	Video attendance for a person by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine if: (a) the attendance follows referral of the patient to the consultant occupational physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is after the first in a single course of treatment.	$189.30
92750	Phone attendance for a person by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine if: (a) the attendance follows referral of the patient to the consultant occupational physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is after the first attendance in a single course of treatment.	$189.30
92751	Video attendance for a person by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; (c) the attendance is an initial attendance in a single course of treatment; and (d) the attendance on the patient, being an attendance to which item 2801, 91824 or 110 applies did not take place on the same day by the same pain medicine specialist or consultant physician.	$427.40
92752	Video attendance for a person by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is not a minor attendance after the first in a single course of treatment.	$213.80
92753	Video attendance for a person by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a minor attendance after the first in a single course of treatment.	$189.30
92754	Phone attendance for a person by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a minor attendance after the first of a single course of treatment.	$189.30
92755	Video attendance for a person by a specialist, or consultant physician, in the practice of the specialists or consultant physician's specialty of palliative medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; (c) the attendance is an initial attendance in a single course of treatment; and (d) the attendance on the patient, being an attendance to which item 3005, 91824 or 110 applies did not take place on the same day by the same palliative medicine specialist or consultant physician.	$427.40
92756	Video attendance for a person by a specialist, or consultant physician, in the practice of the specialist's, or consultant physician's, specialty of palliative medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is not a minor attendance after the first in a single course of treatment.	$213.80
92757	Video attendance for a person by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a minor attendance after the first in a single course of treatment.	$264.10
92758	Phone attendance for a person by a specialist, or consultant physician, in the practice of the specialists or consultant physician's specialty of palliative medicine if: (a) the attendance follows referral of the patient to the specialist or consultant physician; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a minor attendance after the first in a single course of treatment.	$189.30
92759	Video attendance for a person by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; (b) the attendance includes a comprehensive assessment; (c) the attendance is the first or only time in a single course of treatment that a comprehensive assessment is provided; and (d) an attendance on the patient, being an attendance to which item 6018, 91824 or 110 applies did not take place on the same day by the same addiction medicine specialist.	$488.30

Item No.	Description	Max Fee (excl. GST)
92760	Video attendance for a person by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a patient assessment: (i) before or after a comprehensive assessment under item 110, 6018, 91824 or 92759 in a single course of treatment; or (ii) that follows an initial assessment under item 132, 6023, 92422 or 92762 in a single course of treatment; or (iii) that follows a review under item 133, 6024, 92423 or 92763 in a single course of treatment.	$264.10
92761	Phone attendance for a person by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a minor attendance after the first in a single course of treatment.	$189.30
92762	Video attendance for a person by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 91824, 91825, 91826, 91836, 92759, 92760, 92763, 132, 133, 6018, 6019 or 6023 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 6023, 132 or 92422 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist	$760.40
92763	Video attendance for a person by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018, 6019, 91824, 91825, 91826, 91836, 92423, 92759 or 6024 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 132, 6023, 92422 or 92762 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 132, 6023, 92422, or 92762 by locum tenens; and (f) this item has not applied more than twice in any 12-month period.	$380.80
92764	Video attendance for a person by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty if: (a) the attendance follows referral of the patient to the sexual health medicine specialist; and (b) the attendance is of more than 5 minutes in duration, and includes a comprehensive assessment; and (c) the attendance is the first or only time in a single course of treatment; and (d) an attendance on the patient, being an attendance to which item 6051, 91824, or 110 applies did not take place on the same day by the same sexual health medicine specialist.	$427.40
92765	Video attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty if: (a) the attendance follows referral of the patient to the specialist; (b) the attendance is a patient assessment: (i) before or after a comprehensive assessment under item 6051, 91824 or 92764 in a single course of treatment; or (ii) that follows an initial assessment under item 6057 or 92767 in a single course of treatment; or (iii) that follows a review under item 6058 or 92768 in a single course of treatment.	$213.80
92766	Phone attendance for a person by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty if: (a) the attendance follows referral of the patient to the sexual health medicine specialist; and (b) the attendance is of more than 5 minutes in duration; and (c) the attendance is a minor attendance after the first in a single course of treatment.	$189.30
92767	Video attendance for a person by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of sexual health of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051, 6052, 6057, 91822, 91823, 91824, 91825, 91826, 91833, 91836, 92422, 92423, 92764, or 92765 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor items 6057, 92422 or 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist.	$747.30

Item No.	Description	Max Fee (excl. GST)
92768	Video attendance for a person by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051, 6052, 91822, 91823, 91824, 91825, 91826, 91836, 92422, 92423, 92764, 92765 or 6058 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057, 132, 92422 or 92767 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057, 132, 92422 or 92767 by locum tenens; and (f) neither this item nor item 6058 has not applied more than twice in any 12-month period.	$374.20
GROUP A48—GENERAL PRACTITIONER ATTENDANCES—TELEHEALTH RELATED		
	General practitioner patient end support for video conferencing consultations	
02484	Professional attendance by a general practitioner, at consulting rooms, lasting at least 6 minutes but less than 20 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the medical practitioner is located in the same room as the patient for the whole of the attendance	$157.20
02485	Professional attendance by a general practitioner, at a place other than consulting rooms, lasting at least 6 minutes but less than 20 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$182.40
02486	Professional attendance by a general practitioner, at a residential aged care facility, lasting at least 6 minutes but less than 20 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$157.20
02487	Professional attendance by a general practitioner, at consulting rooms, lasting at least 20 minutes but less than 40 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the medical practitioner is located in the same room as the patient for the whole of the attendance	$258.10
02488	Professional attendance by a general practitioner, at a place other than consulting rooms, lasting at least 20 minutes but less than 40 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$283.30
02489	Professional attendance by a general practitioner, at a residential aged care facility, lasting at least 20 minutes but less than 40 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$258.10
02490	Professional attendance by a general practitioner, at consulting rooms, lasting at least 40 minutes but less than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the medical practitioner is located in the same room as the patient for the whole of the attendance	$356.90
02491	Professional attendance by a general practitioner, at a place other than consulting rooms, lasting at least 40 minutes but less than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$375.80
02492	Professional attendance by a general practitioner, at a residential aged care facility, lasting at least 40 minutes but less than 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$356.90

Item No.	Description	Max Fee (excl. GST)
02493	Professional attendance by a general practitioner, at consulting rooms, lasting at least 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the medical practitioner is located in the same room as the patient for the whole of the attendance	$547.70
02494	Professional attendance by a general practitioner, at a place other than consulting rooms, lasting at least 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is not a care recipient in a residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$572.90
02495	Professional attendance by a general practitioner, at a residential aged care facility, lasting at least 60 minutes, if: (a) the attendance is to provide clinical support to a patient to whom a specialist or consultant physician is providing a service, to which another item applies, by way of a video conferencing consultation; and (b) the patient is not an admitted patient; and (c) the patient is a care recipient in the residential aged care facility; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance	$547.70
GROUP A9—CONTACT LENSES—ATTENDANCES		
10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye	$348.80
10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye	$348.80
10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with astigmatism of 3.0 dioptres or greater in one eye	$348.80
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	$348.80
10805	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	$348.80
10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system	$348.80
10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity-whether congenital, traumatic or surgical in origin	$348.80
10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient who, because of physical deformity, are unable to wear spectacles	$348.80
10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account	$348.80
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply	$344.60

Item No.	Description	Max Fee (excl. GST)
GROUP D1—MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		
	Neurology	
11000	Electroencephalography, other than a service: (a) associated with a service to which item 11003, 11009 or 11205 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.)	$292.50
11003	Electroencephalography, prolonged recording lasting at least 3 hours, that requires multi channel recording using: (a) for a service not associated with a service to which an item in Group T8 applies standard 10 20 electrode placement; or (b) for a service associated with a service to which an item in Group T8 applies either standard 10 20 electrode placement or a different electrode placement and number of recorded channels; other than a service: (c) associated with a service to which item 11000, 11004 or 11005 applies; or (d) involving quantitative topographic mapping using neurometrics or similar devices.	$784.40
11004	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, first day, other than a service: (a) associated with a service to which item 11000, 11003 or 11005 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices.	$741.10
11005	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, each day after the first day, other than a service: (a) associated with a service to which item 11000, 11003 or 11004 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices.	$762.80
11009	Electrocorticography	$542.60
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies)	$262.40
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies)	$359.30
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies)	$508.70
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations	$355.30
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies	$272.20
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies	$402.10
	Ophthalmology	
11200	Provocative test or tests for open angle glaucoma, including water drinking	$96.50
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality.	$252.00
11205	Electrooculography of one or both eyes performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty, other than a service associated with a service to which item 11000, 11340, 11341 or 11343 applies	$252.00
11210	Pattern electroretinography of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of the specialist's or consultant physician's speciality	$252.00
11211	Dark adaptometry of one or both eyes with a quantitative estimation of threshold in log lumens at 45 minutes of dark adaptations, performed by or on behalf of a specialist in the practice of the specialist's specialty of ophthalmology	$252.00
11215	Retinal angiography, multiple exposures of 1 eye with intravenous dye injection	$291.90
11218	Retinal angiography, multiple exposures of both eyes with intravenous dye injection	$361.10

Item No.	Description	Max Fee (excl. GST)
11219	Optical coherence tomography for diagnosis of an ocular condition for the treatment of which there is a medication that is: (a) listed on the pharmaceutical benefits scheme; and (b) indicated for intraocular administration Applicable only once in any 12 month period	$90.60
11220	Optical coherence tomography for the assessment of the need for treatment following provision of pharmaceutical benefits scheme-subsidised ocriplasmin. Maximum of one service per eye per lifetime.	$90.60
11221	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral to a maximum of 3 examinations (including examinations to which item 11224 applies) in any 12 month period	$163.30
11224	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral to a maximum of 3 examinations (including examinations to which item 11221 applies) in any 12 month period	$91.10
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	$292.00
11237	OCULAR CONTENTS, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, not being a service associated with a service to which items in Group I1 of Category 5 apply	$194.40
11240	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 of Category 5 apply.	$194.40
11241	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply	$245.70
11242	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply	$191.10
11243	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply	$186.50
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.	$174.60
	Otolaryngology	
11300	Brain stem evoked response audiometry, if: (a) the service is not for the purposes of programming either an auditory implant or the sound processor of an auditory implant; and (b) a service to which item 82300 applies has not been performed on the patient on the same day (Anaes.)	$429.80
11302	Programming an auditory implant or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which item 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11342 or item 11345 applies on the same day	$387.00
11303	Electrocochleography, extratympanic method, 1 or both ears	$429.80
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears	$770.30
11306	Non determinate audiometry, if a service to which item 82306 applies has not been performed on the patient on the same day.	$53.10
11309	Audiogram, air conduction, if a service to which item 82309 applies has not been performed on the patient on the same day.	$62.10
11312	Audiogram, air and bone conduction or air conduction and speech discrimination, if a service to which item 82312 applies has not been performed on the patient on the same day.	$89.90
11315	Audiogram, air and bone conduction and speech, if a service to which item 82315 applies has not been performed on the patient on the same day	$117.50
11318	Audiogram, air and bone conduction and speech, with other cochlear tests, if a service to which item 82318 applies has not been performed on the patient on the same day	$143.70

Item No.	Description	Max Fee (excl. GST)
11324	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a medical practitioner, if a service to which item 82324 applies has not been performed on the patient on the same day	$71.50
11332	Oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlea, performed by or on behalf of a specialist or consultant physician, when middle ear pathology has been excluded, if: (a) the service is performed: (i) on an infant or child who is at risk of permanent hearing impairment; or (ii) on an individual who is at risk of oto-toxicity due to medications or medical intervention; or (iii) on an individual at risk of noise induced hearing loss; or (iv) to assist in the diagnosis of auditory neuropathy; and (b) a service to which item 82332 applies has not been performed on the patient on the same day	$136.50
11340	Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular motor function; and (b) using up to 2 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027 or 11205 applies	$374.20
11341	Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular motor function; and (b) using 3 or 4 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027 or 11205 applies	$750.10
11342	Programming by video attendance of an auditory implant, or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which items 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11302 or item 11345 applies on the same day	$326.80
11343	Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular motor function; and (b) using 5 or more clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027 or 11205 applies	$1,122.10
11345	Programming by phone attendance of an auditory implant, or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which items 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11302 or item 11342 applies on the same day	$326.80
	Respiratory	
11503	Complex measurement of properties of the respiratory system, including the lungs and respiratory muscles, that is performed: (a) in a respiratory laboratory; and (b) under the supervision of a specialist or consultant physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and (c) using any of the following tests: (i) measurement of absolute lung volumes by any method; (ii) measurement of carbon monoxide diffusing capacity by any method; (iii) measurement of airway or pulmonary resistance by any method; (iv) inhalation provocation testing, including pre provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post bronchodilator spirometry; (v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers; (vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support; (vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes; (viii) simulated altitude test involving exposure to hypoxic gas mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen; (ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for a duration of 15 minutes or greater; (x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen functional exercise test by any method (including 6 minute walk test and shuttle walk test); each occasion at which one or more tests are performed Not applicable to a service performed in association with a spirometry or sleep study service to which item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Not applicable to a service to which item 11507 applies	$326.00
11505	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation; each occasion at which 3 or more recordings are made Applicable only once in any 12 month period	$89.60

Item No.	Description	Max Fee (excl. GST)
11506	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to: (i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or (ii) assess acute exacerbations of asthma; or (iii) monitor asthma and COPD; or (iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease; each occasion at which recordings are made	$45.60
11507	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) fractional exhaled nitric oxide (FeNO) concentration in exhaled breath; if: (c) the measurement is performed: (i) under the supervision of a specialist or consultant physician; and (ii) with continuous attendance by a respiratory scientist; and (iii) in a respiratory laboratory equipped to perform complex lung function tests; and (d) a permanently recorded tracing and written report is provided; and (e) 3 or more spirometry recordings are performed unless difficult to achieve for clinical reasons; each occasion at which one or more such tests are performed Not applicable to a service associated with a service to which item 11503 or 11512 applies	$218.30
11508	Maximal symptom limited incremental exercise test using a calibrated cycle ergometer or treadmill, if: (a) the test is performed for the evaluation of: (i) breathlessness of uncertain cause from tests performed at rest; or (ii) breathlessness out of proportion with impairment due to known conditions; or (iii) functional status and prognosis in a patient with significant cardiac or pulmonary disease for whom complex procedures such as organ transplantation are considered; or (iv) anaesthetic and perioperative risks in a patient undergoing major surgery who is assessed as substantially above average risk after standard evaluation; and (b) the test has been requested by a specialist or consultant physician following professional attendance on the patient by the specialist or consultant physician; and (c) a respiratory scientist and a medical practitioner are in constant attendance during the test; and (d) the test is performed in a respiratory laboratory equipped with airway management and defibrillator equipment; and (e) there is continuous measurement of at least the following: (i) work rate; (ii) pulse oximetry; (iii) respired oxygen and carbon dioxide partial pressures and respired volumes; (iv) ECG; (v) heart rate and blood pressure; and (f) interpretation and preparation of a permanent report is provided by a specialist or consultant physician who is also responsible for the supervision of technical staff and quality assurance	$633.60
11512	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) that is performed with a respiratory scientist in continuous attendance; and (c) that is performed in a respiratory laboratory equipped to perform complex lung function tests; and (d) that is performed under the supervision of a specialist or consultant physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports; and (e) for which a permanently recorded tracing and written report is provided; and (f) for which 3 or more spirometry recordings are performed; each occasion at which one or more such tests are performed Not applicable for a service associated with a service to which item 11503 or 11507 applies	$147.20
	Vascular	
11600	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter once per day for each type of pressure for a patient, other than a service: (a) associated with the management of general anaesthesia; and (b) to which item 13876 applies (H)	$156.90
11602	Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsalva manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 applies hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of 2 examinations in a 12 month period, not to be used in conjunction with sclerotherapy	$138.70
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography) examination, hard copy trace and written report, not being a service associated with a service to which item 32500 applies	$144.90
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 applies	$140.90
11607	Continuous ambulatory blood pressure recording for 24 hours or more for a patient if: (a) the patient has a clinic blood pressure measurement (using a sphygmomanometer or a validated oscillometric blood pressure monitoring device) of either or both of the following measurements: (i) systolic blood pressure greater than or equal to 140mmHg and less than or equal to 180mmHg; (ii) diastolic blood pressure greater than or equal to 90mmHg and less than or equal to 110mmHg; and (b) the patient has not commenced anti hypertensive therapy; and (c) the recording includes the patient s resting blood pressure; and (d) the recording is conducted using microprocessor based analysis equipment; and (e) the recording is interpreted by a medical practitioner and a report is prepared by the same medical practitioner; and (f) a treatment plan is provided for the patient; and (g) the service: (i) is not provided in association with ambulatory electrocardiogram recording, and (ii) is not associated with a service to which any of the following items apply: (A) 177; (B) 224 to 228; (C) 231 to 244; (D) 392 or 393; (E) 699; (F) 701 to 707; (G) 715; (H) 729, 731, 965 or 967; (I) 735 to 758; (J) 92004, 92011, 92026, 92027, 92029, 92030, 92057, 92058, 92060 or 92061. Applicable only once in any 12 month period	$227.80

Item No.	Description	Max Fee (excl. GST)
11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report.	$138.70
11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report.	$138.70
11612	EXERCISE STUDY FOR THE EVALUATION OF LOWER EXTREMITY ARTERIAL DISEASE, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment where the exercise workload is quantifiably documented, examination and report.	$217.60
11614	Transcranial doppler, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, other than a service associated with a service to which item 55280 of the diagnostic imaging services table applies	$144.90
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.	$172.50
11627	Pulmonary artery pressure monitoring during open heart surgery, in a patient under 12 years of age (H)	$532.80
	Cardiovascular	
11704	Twelve lead electrocardiography, trace and formal report, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies. Note: the following are also requirements of the service: a formal report is completed; and a copy of the formal report is provided to the requesting practitioner; and the service is not provided to the patient as part of an episode of hospital treatment or hospital-substitute treatment; and is not provided in association with an attendance item (Part 2 of the schedule); and the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner.	$68.50
11705	Twelve lead electrocardiography, formal report only, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the following are also requirements of the service: a formal report is completed; and a copy of the formal report is provided to the requesting practitioner; and the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner.	$40.40
11707	Twelve lead electrocardiography, trace only, by a medical practitioner, if: (a) the trace is provided to a specialist or consultant physician for a formal report; and (b) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	$40.40
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	$166.10
11714	Twelve-lead electrocardiography, trace and clinical note, by a medical practitioner, if: (a) the trace is required to inform clinical decision making during or following an attendance by the medical practitioner; and (b) the clinical note details the clinical indication for the service; and (c) the clinical note includes the interpretation in the context of the indication for the service; and (d) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	$53.10
11716	Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Continuous ambulatory electrocardiogram recording for 12 or more hours, by a specialist or consultant physician, if the service: (a) is indicated for the evaluation of any of the following: (i) syncope; (ii) pre syncopal episodes; (iii) palpitations where episodes are occurring more than once a week; (iv) another asymptomatic arrhythmia is suspected with an expected frequency of greater than once a week; (v) surveillance following cardiac surgical procedures that have an established risk of causing dysrhythmia; and (b) utilises a system capable of superimposition and full disclosure printout of at least 12 hours of recorded electrocardiogram data (including resting electrocardiogram and the recording of parameters) and microprocessor based scanning analysis; and (c) includes interpretation and report; and (d) is not provided in association with ambulatory blood pressure monitoring; and (e) is not associated with a service to which item 11704, 11705, 11707, 11714, 11717, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 4 week period Note: this services does not apply if the patient is being provided with the service as part of an episode of: hospital treatment; or hospital substitute treatment.	$366.80

Item No.	Description	Max Fee (excl. GST)
11717	Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event memory recording device that: (i) is connected continuously to the patient for between 7 and 30 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and reporting (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: unexplained syncope; or palpitation; or other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item 11716, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period Note: the service does not apply if the patient is being provided with the service as part of an episode of: hospital treatment; or hospital substitute treatment.	$215.60
11719	IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period. Payable only once in any 12 month period	$154.40
11720	IMPLANTED PACEMAKER TESTING, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus including reprogramming when required, not being a service associated with a service to which item 11721 applies.	$154.40
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11704, 11719, 11720, 11725 or 11726 applies	$156.90
11723	Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event recording, on a memory recording device that: (i) is connected continuously to the patient for up to 7 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and formal report (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: (i) unexplained syncope; or (ii) palpitation; or (iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item 11716, 11717, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period Note: The service does not apply if the patient is an admitted patient.	$113.70
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	$377.70
11725	IMPLANTED DEFIBRILLATOR (including cardiac resynchronisation defibrillator) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period. Payable only once in any 12 month period	$438.10
11726	Implanted defibrillator testing with patient attendance following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies.	$218.90
11727	IMPLANTED DEFIBRILLATOR TESTING involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, not being a service associated with a service to which item 11719, 11720, 11721, 11725 or 11726 applies	$224.50
11728	Implanted loop recording for the investigation of atrial fibrillation if the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source, including reprogramming when required, retrieval of stored data, analysis, interpretation and report, other than a service to which item 38288 applies For any particular patient applicable not more than 4 times in any 12 months	$77.40
11729	Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, if: (a) the patient is 17 years or more; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period	$333.50

Item No.	Description	Max Fee (excl. GST)
11730	Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), if: (a) the patient is less than 17 years; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes in duration; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period	$333.50
11731	Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming (if required), retrieval of stored data, analysis, interpretation and report, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period	$76.20
11732	Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), performed by a cardiologist with relevant expertise in genetic heart disease, if: (a) the patient is: (i) under investigation or treatment for long QT syndrome, catecholaminergic polymorphic ventricular tachycardia or arrhythmogenic cardiomyopathy; or (ii) a first degree relative of a person with confirmed long QT syndrome, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic cardiomyopathy or unexplained sudden cardiac death at 40 years of age or younger; and (b) the monitoring and recording: (i) is for at least 20 minutes; and (ii) includes resting electrocardiogram; and (c) the cardiologist produces a report that includes interpretation of the monitoring and recording data (commenting on the significance of the data) and discussion of the relationship of the data to clinical decision making for the patient in the clinical context; and (d) the service is not provided on the same occasion as a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies Applicable once per day	$290.00
11735	Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Continuous ambulatory electrocardiogram recording for 7 days, by a specialist or consultant physician, if the service: (a) utilises intelligent microprocessor based monitoring, with patient triggered recording and symptom reporting capability, real time analysis of electrocardiograms and alerts and daily or live data uploads; and (b) is for the investigation of: (i) episodes of suspected intermittent cardiac arrhythmia or episodes of syncope; or (ii) suspected intermittent cardiac arrhythmia in a patient who has had a previous cerebrovascular accident, is at risk of cerebrovascular accident or has had one or more previous transient ischemic attacks; and (c) includes interpretation and report; and (d) is not a service: (i) provided in association with ambulatory blood pressure monitoring; or (ii) associated with a service to which item 11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than 4 times in any 12 month period Note: The service does not apply if the patient is an admitted patient.	$280.20
11736	Implanted loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), for the investigation of atrial fibrillation, if the service: (a) is provided to a patient who has been diagnosed as having had an embolic stroke of undetermined source; and (b) is not a service to which item 38288 applies Applicable not more than 4 times in any 12 month period	$74.90
11737	Implanted electrocardiogram loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), by a medical practitioner, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period	$74.90
	Gastroenterology and colorectal	
11800	Oesophageal motility test, manometric	$389.40
11801	Clinical assessment of gastro oesophageal reflux disease that involves 48 hour catheter free wireless ambulatory oesophageal pH monitoring, including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if: (a) a catheter based ambulatory oesophageal pH monitoring: (i) has been attempted on the patient but failed due to clinical complications; or (ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter based pH monitoring; and (b) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (H) (Anaes.)	$607.80
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation	$402.40

Item No.	Description	Max Fee (excl. GST)
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is provided to a patient who: (i) has overt gastrointestinal bleeding; or (ii) has gastrointestinal bleeding that is recurrent or persistent, and iron deficiency anaemia that is not due to coeliac disease, and, if the patient also has menorrhagia, has had the menorrhagia considered and managed; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with a service to which item 30680, 30682, 30684 or 30686 applies	$2,747.20
11823	Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy.	$3,787.00
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex	$365.10
11833	Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	$566.80
	Gentio/urinary physiological investigations	
11900	Urine flow study, including peak urine flow measurement, not being a service associated with a service to which item 11912, 11917 or 11919 applies	$62.40
11912	Cystometrography: (a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and (b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible;not being a service associated with a service to which any of items 11012 to 11027, 11900, 11917, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.)	$434.20
11917	Cystometrography, in conjunction with real time ultrasound of one or more components of the urinary tract: (a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and (b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible;including all imaging associated with cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11900, 11912, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.)	$1,022.10
11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography, being a service associated with a service to which items 60506 or 60509 applies; other than a service associated with a service to which items 11012-11027, 11900-11917 and 36800 apply (Anaes.)	$1,022.10
	Allergy testing	
12000	Skin prick testing for aeroallergens by a specialist or consultant physician in the practice of the specialist or consultant physician's specialty, including all allergens tested on the same day, not being a service associated with a service to which item 12001, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies	$92.40
12001	Skin prick testing for aeroallergens, including all allergens tested on the same day, not being a service associated with a service to which item 12000, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies. Applicable only once in any 12 month period	$85.00
12002	Repeat skin prick testing of a patient for aeroallergens, including all allergens tested on the same day, if: (a) further testing for aeroallergens is indicated in the same 12 month period to which item 12001 applies to a service for the patient; and (b) the service is not associated with a service to which item 12000, 12001, 12005, 12012, 12017, 12021, 12022 or 12024 applies Applicable only once in any 12 month period	$85.00
12003	Skin prick testing for food and latex allergens, including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies	$111.20
12004	Skin testing for medication allergens (antibiotics or non general anaesthetics agents) and venoms (including prick testing and intradermal testing with a number of dilutions), including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies	$128.20

Item No.	Description	Max Fee (excl. GST)
12005	Skin testing: (a) performed by or on behalf of a specialist or consultant physician in the practice of the specialist or consultant physician's specialty; and (b) for agents used in the perioperative period (including prick testing and intradermal testing with a number of dilutions), to investigate anaphylaxis in a patient with a history of prior anaphylactic reaction or cardiovascular collapse associated with the administration of an anaesthetic; and (c) including all allergens tested on the same day; and (d) not being a service associated with a service to which item 12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies	$172.70
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens	$49.70
12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens	$159.10
12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 50 allergens but not more than 75 allergens	$260.20
12022	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 75 allergens but not more than 100 allergens	$307.40
12024	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 100 allergens	$349.60
	Other diagnostic procedures and investigations	
12200	Collection of specimen of sweat by iontophoresis	$83.20
12201	Administration, by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness applicable once only in a 12 month period	$4,455.90
12203	Overnight diagnostic assessment of sleep, for at least 8 hours, for a patient aged 18 years or more, to confirm diagnosis of a sleep disorder, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP Bang score of 3 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face to face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that assessment is necessary to confirm the diagnosis of a sleep disorder; and (b) the overnight diagnostic assessment is performed to investigate: (i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study; or (ii) suspected central sleep apnoea syndrome; or (iii) suspected sleep hypoventilation syndrome; or (iv) suspected sleep related breathing disorders in association with non respiratory co morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism; or (v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or (vi) suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours or failure to respond to conventional therapy); or (vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and (c) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service described in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	$1,373.90

Item No.	Description	Max Fee (excl. GST)
12204	Overnight assessment of positive airway pressure, for at least 8 hours, for a patient aged 18 years or more, if: (a) the necessity for an intervention sleep study is determined by a qualified adult sleep medicine practitioner or consultant respiratory physician where a diagnosis of a sleep related breathing disorder has been made; and (b) the patient has not undergone positive airway pressure therapy in the previous 6 months; and (c) following professional attendance on the patient by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face to face or by video conference), the qualified adult sleep medicine practitioner or consultant respiratory physician establishes that the sleep related breathing disorder is responsible for the patient s symptoms; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement; (ix) position; and (f) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (g) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (h) the overnight assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	$1,281.10
12205	Follow up study for a patient aged 18 years or more with a sleep related breathing disorder, following professional attendance on the patient by a qualified adult sleep medicine practitioner or consultant respiratory physician (either face-to-face or by video conference), if: (a) any of the following subparagraphs applies: (i) there has been a recurrence of symptoms not explained by known or identifiable factors such as inadequate usage of treatment, sleep duration or significant recent illness; (ii) there has been a significant change in weight or changes in co morbid conditions that could affect sleep related breathing disorders, and other means of assessing treatment efficacy (including review of data stored by a therapy device used by the patient) are unavailable or have been equivocal; (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical evidence of sub optimal response or uncertainty about control of sleep disordered breathing; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) the follow up study is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	$1,281.10
12207	Overnight investigation, for a patient aged 18 years or more, for a sleep related breathing disorder, following professional attendance by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face to face or by video conference), if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen) (ix) position; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient; and (h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and (i) if the patient has severe respiratory failure a further investigation is indicated in the same 12 month period to which items 12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep Applicable only once in any 12 month period	$1,373.90

Item No.	Description	Max Fee (excl. GST)
12208	Overnight investigation, for sleep apnoea for at least 8 hours, for a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or consultant respiratory physician has determined that the investigation is necessary to confirm the diagnosis of a sleep disorder; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) a further investigation is indicated in the same 12 month period to which item 12203 applies to a service for the patient because insufficient sleep was acquired, as evidenced by a sleep efficiency of 25% or less, during the previous investigation to which that item applied; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	$1,281.10
12210	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	$1,635.10
12213	Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	$1,473.10

Item No.	Description	Max Fee (excl. GST)
12215	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12210 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12210 applied for the patient, and further titration of respiratory support is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12210 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and (h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item 12210 applies	$1,635.10
12217	Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12213 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12213 applied for the patient, and further titration is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and (h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item 12213 applies	$1,473.10

Item No.	Description	Max Fee (excl. GST)
12250	Overnight investigation of sleep for at least 8 hours of a patient aged 18 years or more to confirm diagnosis of obstructive sleep apnoea, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP Bang score of 3 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face to face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that investigation is necessary to confirm the diagnosis of obstructive sleep apnoea; and (b) during a period of sleep, there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) continuous ECG; (iv) continuous EEG; (v) EOG; (vi) oxygen saturation; (vii) respiratory effort; and (c) the investigation is performed under the supervision of a qualified adult sleep medicine practitioner; and (d) either: (i) the equipment is applied to the patient by a sleep technician; or (ii) if this is not possible the reason it is not possible for the sleep technician to apply the equipment to the patient is documented and the patient is given instructions on how to apply the equipment by a sleep technician supported by written instructions; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11714, 11716, 11717, 11723, 11735 and 12203 is provided to the patient Applicable only once in any 12 month period	$785.20
12254	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight investigation a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12258 is provided to the patient Applicable only once in a 12 month period	$1,991.00
12258	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to objectively confirm the ability to maintain wakefulness; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient Applicable only once in a 12 month period	$1,991.00

Item No.	Description	Max Fee (excl. GST)
12261	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12265 is provided to the patient Applicable only once in a 12 month period	$2,087.40
12265	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12261 is provided to the patient Applicable only once in a 12 month period	$2,087.40
12268	Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if: (a) a qualified paediatric sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12272 is provided to the patient Applicable only once in a 12 month period	$2,238.90

Item No.	Description	Max Fee (excl. GST)
12272	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if: (a) a qualified paediatric sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12268 is provided to the patient Applicable only once in a 12 month period	$2,238.90
12306	Bone densitometry, using dual energy X ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting), for: (a) confirmation of a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; or (b) monitoring of low bone mineral density proven by bone densitometry at least 12 months previously; other than a service associated with a service to which item 12312, 12315 or 12321 applies For any particular patient, once only in a 24 month period	$242.80
12312	Bone densitometry, using dual energy X ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following: (a) prolonged glucocorticoid therapy; (b) any condition associated with excess glucocorticoid secretion; (c) male hypogonadism; (d) female hypogonadism lasting more than 6 months before the age of 45; other than a service associated with a service to which item 12306, 12315 or 12321 applies For any particular patient, once only in a 12 month period	$242.80
12315	Bone densitometry, using dual energy X ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following conditions: (a) primary hyperparathyroidism; (b) chronic liver disease; (c) chronic renal disease; (d) any proven malabsorptive disorder; (e) rheumatoid arthritis; (f) any condition associated with thyroxine excess; other than a service associated with a service to which item 12306, 12312 or 12321 applies For any particular patient, once only in a 24 month period	$242.80
12320	Bone densitometry, using dual energy X ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if: (a) the patient is 70 years of age or over, and (b) either: (i) the patient has not previously had bone densitometry; or (ii) the t-score for the patient's bone mineral density is -1.5 or more; other than a service associated with a service to which item 12306, 12312, 12315, 12321 or 12322 applies For any particular patient, once only in a 5 year period	$228.30
12321	Bone densitometry, using dual energy X ray absorptiometry, involving the measurement of 2 or more sites at least 12 months after a significant change in therapy (including interpretation and reporting), for: (a) established low bone mineral density; or (b) confirming a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; other than a service associated with a service to which item 12306, 12312 or 12315 applies For any particular patient, once only in a 12 month period	$242.80
12322	Bone densitometry, using dual energy X ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if: (a) the patient is 70 years of age or over; and (b) the t score for the patient's bone mineral density is less than 1.5 but more than 2.5; other than a service associated with a service to which item 12306, 12312, 12315, 12320 or 12321 applies For any particular patient, once only in a 2 year period	$228.30
12325	Assessment of visual acuity and bilateral retinal photography with a non mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the patient is of Aboriginal and Torres Strait Islander descent; and (b) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (c) this item and item 12326 have not applied to the patient in the preceding 12 months; and (d) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation	$108.80

Item No.	Description	Max Fee (excl. GST)
12326	Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (b) this item and item 12325 have not applied to the patient in the preceding 24 months; and (c) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation	$108.80
GROUP D2—NUCLEAR MEDICINE(NON-IMAGING)		
12500	Blood volume estimation	$519.30
12524	Renal function test (without imaging procedure)	$370.50
12527	Renal function test (with imaging and at least 2 blood samples)	$198.80
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled 13CO2 or 14CO2, for either: (a) the confirmation of Helicobacter pylori colonisation, OR (b) the monitoring of the success of eradication of Helicobacter pylori in patients with peptic ulcer disease. not being a service to which 66900 applies	$198.10
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 at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance (H)	$593.50
13020	Hyperbaric oxygen therapy, for treatment of decompression illness, gas gangrene, air or gas embolism, diabetic wounds (including diabetic gangrene and diabetic foot ulcers) or 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 at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance (H)	$606.60
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) (H)	$275.00
13030	Hyperbaric oxygen therapy performed in a comprehensive hyperbaric medicine facility, if 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) (H)	$382.60
	Dialysis	
13100	Supervision in hospital by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, if the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in one day (H)	$326.30
13103	Supervision in hospital by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, if the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in one day (H)	$170.10
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	$346.70
13105	Haemodialysis for a patient with end stage renal disease if: (a) the service is provided by a registered nurse, an Aboriginal and Torres Strait Islander health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and (b) the service is supervised by the medical practitioner (either in person or remotely); and (c) the patient s care is managed by a nephrologist; and (d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and (e) the patient is not an admitted patient of a hospital; and (f) the service is provided in a Modified Monash 7 area	$1,289.90
13106	Declotting of an arteriovenous shunt	$282.00
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)	$540.50
13110	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.)	$532.40

Item No.	Description	Max Fee (excl. GST)
	Assisted reproductive services	
13202	Assisted reproductive technologies superovulated treatment cycle that is cancelled before oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones and ultrasound examinations, but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13201, 13203 or 13218 applies, being services rendered during one treatment cycle	$1,000.00
13203	Ovulation monitoring services for artificial insemination or gonadotrophin, stimulated ovulation induction, including quantitative estimation of hormones and ultrasound examinations, being services rendered during one treatment cycle but excluding a service to which item 13200, 13201, 13202, 13212, 13215 or 13218 applies	$1,089.20
13209	Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination applicable once during a treatment cycle	$201.40
13212	Oocyte retrieval for the purpose of assisted reproductive technologies only if rendered in connection with a service to which item 13200 or 13201 applies (Anaes.)	$848.60
13215	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination only if rendered in connection with a service to which item 13200, 13201 or 13218 applies, being services rendered in one treatment cycle (Anaes.)	$264.30
13218	Preparation of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in one treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203 or 13212 applies (Anaes.)	$1,814.50
13221	Preparation of semen for the purpose of artificial insemination only if rendered in connection with a service to which item 13203 applies	$112.50
13241	Open surgical testicular sperm retrieval, unilateral, using operating microscope, including the exploration of scrotal contents, with biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, not being a service associated with a service to which item 13218 or 37604 applies (H) (Anaes.)	$1,804.60
13251	Intracytoplasmic sperm injection for the purpose of assisted reproductive technologies, for male factor infertility, excluding a service to which item 13203 or 13218 applies	$935.90
13260	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime.	$904.20
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	$475.80
	Paediatric and neonatal	
13300	Umbilical or scalp vein catheterisation in a neonate with or without infusion or cannulation of a vein (H)	$132.70
13303	Umbilical artery catheterisation with or without infusion (H)	$196.80
13306	Blood transfusion with venesection and complete replacement of blood, including collection from donor (H)	$778.00
13309	Blood transfusion with venesection and complete replacement of blood, using blood already collected (H)	$663.60
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS	$66.20
13318	Central vein catheterisation by open exposure, in a patient under 12 years of age (H) (Anaes.)	$529.80
13319	Central vein catheterisation in a neonate via peripheral vein (H) (Anaes.)	$529.80
	Cardiovascular	
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (H) (Anaes.)	$222.10
	Gastroenterology	
13506	Gastro oesophageal balloon intubation for control of bleeding from gastric oesophageal varices (H)	$430.40
	Haematology	
13700	Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (H) (Anaes.)	$796.90

Item No.	Description	Max Fee (excl. GST)
13703	Transfusion of blood including collection from donor, when used for intra operative normovolaemic haemodilution, other than a service associated with a service to which item 22052 applies (H)	$290.70
13706	Transfusion of blood or bone marrow already collected	$198.50
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, other than a service associated with a service to which item 13755 applies each day (H)	$325.00
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 other than a service associated with a service to which item 13750 applies each day (H)	$325.00
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	$157.20
13760	In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high dose chemotherapy for management of: (a) aggressive malignancy; or (b) malignancy that has proven refractory to prior treatment (H)	$1,830.90
	Procedures associated with intensive care and cardiopulmonary support	
13815	Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (H) (Anaes.)	$207.60
13818	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (H) (Anaes.)	$254.40
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician each day (H)	$180.80
13832	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno arterial cardiopulmonary extracorporeal life support (H)	$1,902.90
13834	Veno arterial cardiopulmonary extracorporeal life support, management of the first day (H)	$1,065.30
13835	Veno arterial cardiopulmonary extracorporeal life support, management of each day after the first (H)	$248.00
13837	Veno-venous pulmonary extracorporeal life support, management of the first day (H)	$1,065.30
13838	Veno-venous pulmonary extracorporeal life support, management of each day after the first (H)	$248.00
13839	Arterial puncture and collection of blood for diagnostic purposes	$53.90
13840	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support (H)	$1,274.80
13842	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both) No separate ultrasound item is payable with this item	$164.10
13848	Counterpulsation by intra aortic balloon management, including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day each day (H)	$332.80
13851	Ventricular assist device (excluding intravascular microaxial ventricular assist device inserted into the right ventricle), management of, for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device first day (H)	$1,177.50
13854	Ventricular assist device (excluding intravascular microaxial ventricular assist device inserted into the right ventricle), management of, for a patient admitted to an intensive care unit, including management of complications arising from implantation or management of the device each day after the first day (H)	$272.80
13857	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit	$336.80
	Management and procedures undertaken in an intensive care unit	
13870	(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit) MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day (H)	$808.40
13873	Management of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day (H)	$592.40

Item No.	Description	Max Fee (excl. GST)
13876	Central venous pressure, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - once only for each type of pressure on any calendar day (up to a maximum of 4 pressures) (H)	$166.30
13881	Airway access, establishment of and initiation of mechanical ventilation, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support (H)	$349.20
13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day (H)	$275.00
13885	Continuous arterio venous or veno venous haemofiltration, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day (H)	$366.30
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day (H)	$171.60
13899	Preparation of Goals of Care is provided outside of an intensive care unit. Refer to explanatory note TN.1.11 for further information about Goals of Care attendance Professional attendance, outside an intensive care unit, for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by a specialist in the specialty of intensive care who takes overall responsibility for the preparation of the goals of care for the patient Item 13899 cannot be co-claimed with item 13870 or item 13873 on the same day	$577.90
	Chemotherapeutic procedures	
13950	Parenteral administration of one or more antineoplastic agents, including agents used in cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of a specialist or consultant physician attendance for one or more episodes of administration Note: The fee for item 13950 contains a component which covers the accessing of a long-term drug delivery device. TN.1.27 refers	$236.80
	Dermatology	
14050	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology Applicable not more than 150 times in a 12 month period	$123.60
14100	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if: (a) the abnormality is visible from 3 metres; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes; to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.)	$425.30
14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period area of treatment less than 150cm^2 (Anaes.)	$425.30
14115	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period area of treatment 150cm^2 to 300cm^2 (Anaes.)	$625.20
14118	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period area of treatment more than 300 cm^2 (Anaes.)	$876.10
14124	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	$337.80
	Other therapeutic procedures	
14201	Poly-l-lactic acid, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the national health act 1953 - once per patient	$544.50

Item No.	Description	Max Fee (excl. GST)
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	$275.50
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)	$114.90
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula	$81.00
14212	Intussusception, management of fluid or gas reduction for (H) (Anaes.)	$434.20
14216	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) has not previously received any prior transcranial magnetic stimulation therapy in a public or private setting; and (b) is at least 18 years old; and (c) is diagnosed with a major depressive episode; and (d) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient s adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (e) has undertaken psychological therapy, if clinically appropriate	$395.90
14217	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 35 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received a service under item 14216 each service up to 35 services	$339.80
14218	Implanted infusion pump, refilling of reservoir with a therapeutic agent or agents for infusion to the subarachnoid space or accessing the side port to assess catheter patency, with or without pump reprogramming, for the management of chronic pain, including cancer pain	$222.10
14219	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) is at least 18 years old; and (b) is diagnosed with a major depressive episode; and (c) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient s adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (d) has undertaken psychological therapy, if clinically appropriate; and (e) has previously received an initial service under item 14217 and the patient: (i) has relapsed after a remission following the initial service; and (ii) has had a satisfactory clinical response to the service under item 14217 (which has been assessed by a validated major depressive disorder tool at least 4 months after receiving that service)	$395.90
14220	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 15 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received: (a) a service under item 14217 (which was not provided in the previous 4 months); and (b) a service under item 14219 Each service up to 15 services	$339.80
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13950 applies	$125.40
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (H) (Anaes.)	$293.00
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	$228.30
14234	Infusion pump or components of an infusion pump, removal or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.)	$792.80
14237	Infusion pump or components of an infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.)	$1,445.60
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	$228.30
14247	Extracorporeal photopheresis for the treatment of erythrodermic stage III IVa T4 M0 cutaneous T cell lymphoma; if (a) the service is provided in the initial six months of treatment; and (b) the service is delivered using an integrated, closed extracorporeal photopheresis system; and (c) the patient is 18 years old or over; and (d) the patient has received prior systemic treatment for this condition and experienced either disease progression or unacceptable toxicity while on this treatment; and (e) the service is provided in combination with the use of Pharmaceutical Benefits Scheme subsidised methoxsalen; and (f) the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle (H)	$4,053.50

Item No.	Description	Max Fee (excl. GST)
14249	Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III IVa T4 M0 cutaneous T cell lymphoma; if (a) in the preceding 6 months: (i) a service to which item 14247 applies has been provided; and (ii) the patient has demonstrated a response to this service; and (iii) the patient requires further treatment; and (b) the service is delivered using an integrated, closed extracorporeal photopheresis system; and (c) the patient is 18 years old or over; and (d) the service is provided in combination with the use of Pharmaceutical Benefits Scheme subsidised methoxsalen; and (e) the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle (H)	$4,053.50
	Management and procedures undertaken in an emergency department	
14255	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$320.30
14256	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$615.80
14257	Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$1,226.40
14258	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$240.40
14259	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$462.00
14260	Resuscitation of a patient provided for at least 2 hours, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$919.80
14263	Minor procedure on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$112.80
14264	Procedure (except a minor procedure) on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$253.80
14265	Minor procedure on a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$84.50
14266	Procedure (except a minor procedure) on a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$190.40
14270	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a specialist in the practice of the specialist's specialty of emergency medicine in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (b) occurs at a recognised emergency department of a private hospital (Anaes.)	$284.50
14272	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (b) occurs at a recognised emergency department of a private hospital (Anaes.)	$213.60
14277	Application of chemical or physical restraint of a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital	$320.30
14278	Application of chemical or physical restraint of a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital	$240.40

Item No.	Description	Max Fee (excl. GST)
14280	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$320.30
14283	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$240.40
14285	Emergent intubation, airway management or both of a patient that: (a) is managed by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$320.30
14288	Emergent intubation, airway management or both of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$240.40
GROUP T3—THERAPEUTIC NUCLEAR MEDICINE		
16003	Intra-cavitary administration of a therapeutic dose of Yttrium 90 (not including preliminary paracentesis and other than a service to which item 35404, 35406 or 35408 applies or a service associated with selective internal radiation therapy) (Anaes.)	$1,613.20
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	$1,236.80
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	$877.30
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	$759.30
16015	Administration of Strontium 89 for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient s disease and either: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.	$9,256.40
16018	Administration of 153 Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient s disease, and: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.	$4,934.20
GROUP T2—TARGETED INTRAOPERATIVE RADIOTHERAPY		
	Intraoperative radiotherapy	
15900	Breast, malignant tumour, targeted intraoperative radiation therapy, using an Intrabeam or Xoft Axxent device, delivered at the time of breast conserving surgery (partial mastectomy or lumpectomy) for a patient who: (a) is 45 years of age or over; and (b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and (c) has a histologic grade 1 or 2 tumour; and (d) has an oestrogen receptor positive tumour; and (e) has a node negative malignancy; and (f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and (g) has no contra indications to breast irradiation Applicable once per breast per lifetime (H)	$577.80
	Megavoltage Post 1 July 2024	
15902	Megavoltage planning level 1.1 Simple complexity single field radiation therapy simulation and dosimetry for treatment planning, without imaging for field setting, if: (a) all of the following apply in relation to the simulation: (i) the simulation is to one site; (ii) localisation is based on clinical mark up and image based simulation is not required; (iii) patient set up and immobilisation techniques are suitable for two dimensional radiation therapy treatment, with wide margins and allowance for movement; and (b) all of the following apply in relation to the dosimetry: (i) the planning process is required to deliver a prescribed dose to a point, either at depth or on the surface of the patient; (ii) based on review and assessment by a radiation oncologist, the planning process does not require the differential of dose between target, organs at risk and normal tissue dose; (iii) delineation of structures is not possible or required, and field borders will delineate the treatment volume; (iv) doses are calculated in reference to a point, either at depth or on the surface of the patient, from tables, charts or data from a treatment planning system Applicable once per course of treatment	$1,255.80

Item No.	Description	Max Fee (excl. GST)
15904	Megavoltage planning level 1.2 Simple complexity radiation therapy simulation and dosimetry for treatment planning, with imaging for field setting, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for two dimensional radiation therapy dose planning; (ii) patient set up and immobilisation techniques are suitable for two dimensional radiation therapy treatment where interfraction reproducibility is required; (iii) imaging datasets are acquired for the relevant region of interest to be planned; and (b) all of the following apply in relation to the dosimetry: (i) the two dimensional planning process is required to calculate dose to a volume, however a dose volume histogram is not required to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the two dimensional planning process is not required to maximise the differential between target dose and normal tissue dose; (iii) the target (which may include gross, clinical and planning targets as a composite structure or field border outline), as defined in the prescription, is rendered as a two dimensional structure as field borders or a volume; (iv) organs at risk are delineated if required, and assessment of dose to these structures is derived from dose point calculations, rather than full calculation and inclusion in a dose volume histogram; (v) dose calculations are calculated using a specialised algorithm, with prescription and plan details approved and recorded with the plan Applicable once per course of treatment	$1,839.80
15906	Megavoltage planning level 2.1 Three dimensional radiation therapy simulation and dosimetry for treatment planning, without motion management, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for three dimensional planning without consideration of motion management; (ii) patient set up and immobilisation techniques are reproducible for treatment; (iii) a high quality dataset is acquired in treatment position for the relevant region of interest to be planned and treated with image verification; and (b) all of the following apply in relation to the dosimetry: (i) the three dimensional planning process is required to calculate dose to three dimensional volume structures and requires a dose volume histogram to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the three dimensional planning process is required to optimise the differential between target dose and normal tissue dose; (iii) the planning target volume is rendered as a three dimensional structure on planning outputs (three dimensional plan review, three planar sections review or dose volume histogram); (iv) organs at risk are delineated, and assessment of dose to these structures is derived from calculation and inclusion in a dose volume histogram Applicable once per course of treatment	$2,836.70
15908	Megavoltage planning level 2.2 Three dimensional radiation therapy simulation and dosimetry for treatment planning with motion management, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for complex three dimensional planning with consideration of motion management; (ii) patient set up and immobilisation techniques are reproducible for treatment; (iii) a high quality three dimensional or four dimensional image volume dataset is acquired in treatment position for the relevant region of interest to be planned and treated with image verification; and (b) all of the following apply in relation to the dosimetry: (i) the three dimensional planning process is required to calculate dose to three dimensional volume structures (which must include structures moving with physiologic processes) and requires a dose volume histogram to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the three dimensional planning process is required to optimise the differential between target dose and normal tissue dose; (iii) the planning target volume is rendered as a three dimensional structure on planning outputs (three dimensional plan review, three planar sections review or dose volume histogram); (iv) organs at risk are delineated, and assessment of dose to these structures is derived from full calculation and inclusion in a dose volume histogram Applicable once per course of treatment	$4,585.90
15910	Megavoltage planning level 3.1 Standard intensity modulated radiation therapy (IMRT) simulation and dosimetry for treatment planning, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for single dose level IMRT planning without motion management; (ii) patient set up and immobilisation techniques are suitable for image volume data acquisition and reproducible IMRT treatment; (iii) a high quality three dimensional image volume dataset is acquired in treatment position for the relevant region of interest to be planned and treated with image verification; and (b) all of the following apply in relation to the dosimetry: (i) the IMRT planning process is required to calculate dose to a single dose level volume structure and requires a dose volume histogram to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the IMRT planning process optimises the differential between target dose, organs at risk and normal tissue dose; (iii) all relevant gross tumour volumes, clinical target volumes, planning target volumes and organs at risk are rendered as volumes and nominated with planning dose objectives; (iv) organs at risk are nominated as planning dose constraints; (v) dose calculations and dose volume histograms are generated in an inverse planned process using a specialised algorithm, with prescription and plan details approved and recorded with the plan; (vi) a three dimensional image volume dataset is used for the relevant region to be planned and treated with image verification Applicable once per course of treatment	$7,171.10
15912	Megavoltage re planning level 3.1 Additional dosimetry plan for re planning of standard intensity modulated radiation therapy (IMRT) treatment, if: (a) an initial treatment plan described in item 15910 or 15914 has been prepared; and (b) treatment adjustments to the initial plan are inadequate to satisfy treatment protocol requirements Applicable once per course of treatment	$3,585.50

Item No.	Description	Max Fee (excl. GST)
15914	Megavoltage planning level 3.2 Complex intensity modulated radiation therapy (IMRT) simulation and dosimetry for treatment planning, if (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for multiple dose level IMRT planning or single dose level IMRT planning requiring motion management; (ii) patient set up and immobilisation techniques are suitable for image volume data acquisition and reproducible IMRT treatment; (iii) a high quality three dimensional or four dimensional volume dataset is acquired in treatment position for the relevant region of interest to be planned and treated with image verification; and (b) all of the following apply in relation to the dosimetry: (i) the IMRT planning process is required to calculate dose to multiple dose level volume structures or single dose level volume structures (including structures moving with physiologic processes or requiring precise positioning with respect to beam edges) and requires a dose volume histogram to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the IMRT planning process optimises the differential between target dose, organs at risk and normal tissue dose; (iii) all relevant gross tumour targets, clinical target volumes, planning target volumes, internal target volumes and organs at risk are rendered and nominated with planning dose objectives; (iv) organs at risk are nominated as planning dose constraints; (v) dose calculations and dose volume histograms are generated in an inverse planned process using a specialised algorithm, with prescription and plan details approved and recorded with the plan; (vi) a three dimensional or four dimensional image volume dataset is used for the relevant region to be planned and treated, with image verification for a multiple dose level IMRT planning or single dose level IMRT planning requiring motion management Applicable once per course of treatment	$10,306.30
15916	Megavoltage re planning level 3.2 Additional dosimetry plan for re planning of complex intensity modulated radiation therapy (IMRT) treatment, if: (a) an initial treatment plan described in item 15910 or 15914 has been prepared; and (b) treatment adjustments to the initial plan are inadequate to satisfy treatment protocol requirements Applicable once per course of treatment	$5,153.10
15918	Megavoltage planning level 4 Intracranial stereotactic radiation therapy (SRT) simulation and dosimetry for treatment planning, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for multiple non coplanar, rotational or fixed beam stereotactic delivery; (ii) precise personalised patient set up and immobilisation techniques are suitable for reliable imaging acquisition and reproducible SRT small field and ablative treatments; (iii) a high quality three dimensional image volume dataset is acquired in treatment position for the intracranial lesions to be planned and treated and verified; and (b) all of the following apply in relation to the dosimetry: (i) the planning process is required to calculate dose to single or multiple target structures and requires a dose volume histogram to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the planning process maximises the differential between target dose, organs at risk and normal tissue dose; (iii) all relevant gross tumour volumes, clinical target volumes, planning target volumes and organs at risk are rendered and nominated with planning dose objectives; (iv) organs at risk are nominated as planning dose constraints; (v) dose calculations and dose volume histograms are generated using a validated stereotactic type algorithm, with prescription and plan details approved and recorded with the plan Applicable once per course of treatment	$11,556.20
15920	Megavoltage planning level 4 Stereotactic body radiation therapy (SBRT) simulation and dosimetry for treatment planning, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for inverse planning with multiple non coplanar, rotational or fixed beam stereotactic delivery or intensity modulated radiation therapy (IMRT) stereotactic delivery; (ii) personalised patient set up and immobilisation techniques are suitable for reliable imaging acquisition and reproducible, including techniques to minimise motion of organs at risk and targets; (iii) small field and ablative treatment is used; (iv) a high quality three dimensional or four dimensional image volume dataset is acquired in treatment position for the relevant region of interest to be planned, treated and verified (through daily planar or volumetric image guidance strategies); and (b) all of the following apply in relation to the dosimetry: (i) the planning process is required to calculate dose to single or multiple target structures and requires a dose volume histogram to complete the planning process; (ii) based on review and assessment by a radiation oncologist, the planning process maximises the differential between target dose, organs at risk and normal tissue dose; (iii) all relevant gross tumour volumes, clinical target volumes, planning target volumes and organs at risk are rendered and nominated with planning dose objectives; (iv) organs at risk are nominated as planning dose constraints; (v) dose calculations and dose volume histograms are generated using a validated stereotactic type algorithm, with prescription and plan details approved and recorded with the plan Applicable once per course of treatment	$11,556.20
15922	Megavoltage re planning level 4 Additional dosimetry plan for re planning of intracranial stereotactic radiation therapy (SRT) or stereotactic body radiation therapy (SBRT) treatment, if: (a) an initial treatment plan at a level that is equivalent to or higher than that described in item 15918 or 15920 has been prepared; and (b) treatment adjustments to the initial plan are inadequate to satisfy treatment protocol requirements Applicable once per course of treatment	$5,778.20
15924	Megavoltage planning level 5 Specialised radiation therapy simulation and dosimetry for treatment planning, if both of the following apply in relation to the simulation: (a) treatment set up and technique specifications are in preparation for a specialised case with general anaesthetic or sedation supervised by an anaesthetist; (b) a high quality three dimensional or four dimensional image volume dataset is acquired in treatment position for the relevant region of interest to be planned and treated with image verification Applicable once per course of treatment (Anaes.)	$12,197.20

Item No.	Description	Max Fee (excl. GST)
15926	Megavoltage planning level 5 Specialised radiation therapy simulation and dosimetry for treatment planning, if: (a) all of the following apply in relation to the simulation: (i) treatment set up and technique specifications are in preparation for a specialised application such as total skin electron therapy (TSE) or total body irradiation (TBI); (ii) reproducible personalised patient set up and immobilisation techniques are suitable to implement three dimensional radiation therapy, intensity modulated radiation therapy (IMRT) (including multiple non coplanar, rotational or fixed beam treatment delivery) or a specialised total body treatment delivery method; (iii) a specialised dataset of anatomical dimensions is acquired in the treatment position for TSE or TBI; and (b) all of the following apply in relation to the dosimetry: (i) total TSE, TBI, IMRT or multiple non coplanar, rotational or fixed beam treatment is used; (ii) the final dosimetry plan is validated by a radiation therapist and a medical physicist, using quality assurance processes; (iii) the final dosimetry plan is approved, prior to treatment delivery, by a radiation oncologist Applicable once per course of treatment	$12,197.20
15928	Megavoltage re planning level 5 Additional dosimetry plan for re planning of specialised radiation therapy if: (a) an initial treatment plan described in 15924 or 15926 has been prepared; and (b) treatment adjustments to the initial plan are inadequate to satisfy treatment protocol requirements Applicable once per course of treatment (Anaes.)	$6,098.60
15930	Megavoltage treatment level 1.1 Radiation therapy for simple, single field treatment (including electron beam treatments), if: (a) the treatment does not use imaging for field setting; and (b) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (c) the treatment is delivered to implement a one dimensional plan; and (d) a two dimensional single field treatment delivery mode is utilised Applicable up to twice per plan per day	$158.00
15932	Megavoltage treatment level 1.2 Radiation therapy and image verification for simple treatment, with imaging for field setting, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) imaging is used to implement a two dimensional plan, and (c) two dimensional treatment is delivered; and (d) image verification decisions and actions are documented in the patient s record Applicable up to twice per plan per day	$196.80
15934	Megavoltage treatment level 2.1 Radiation therapy and image verification for three dimensional treatment, without motion management, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) imaging is used to implement a standard three dimensional plan; and (c) three dimensional treatment is delivered; and (d) image verification decisions and actions are documented in the patient s record Applicable up to twice per plan per day	$443.00
15936	Megavoltage treatment level 2.2 Radiation therapy and image verification for three dimensional treatment, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) imaging is used to implement a complex three dimensional plan; and (c) complex three dimensional treatment is delivered with management of motion; and (d) image decisions and actions are documented in the patient s record Applicable up to twice per plan per day	$481.90
15938	Megavoltage treatment level 3.1 Standard single dose level intensity modulated radiation therapy (IMRT) treatment and image verification, without motion management, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) imaging is used to implement an IMRT plan described in item 15910 or 15914 Applicable up to twice per plan per day	$481.90
15940	Megavoltage treatment level 3.2 Complex multiple dose level intensity modulated radiation therapy (IMRT) treatment, or single dose level IMRT treatment requiring motion management, and image verification, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) imaging is used (with motion management functionality if required) to implement an IMRT plan described in item 15910 or 15914; and (c) radiation field positioning requires accurate dose delivery to the target; and (d) image decisions and actions are documented in the patient s record Applicable up to twice per plan per day	$530.20
15942	Megavoltage treatment level 4 Intracranial stereotactic radiation therapy treatment and image verification, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) or minimally invasive stereotactic frame localisation is used to implement an intracranial stereotactic treatment plan at a level described in item 15918; and (c) radiation field positioning requires accurate dose delivery to the target; and (d) image decisions and actions are documented in the patient s record Applicable once per day	$1,366.30
15944	Megavoltage treatment level 4 Stereotactic body radiation therapy (SBRT) treatment and image verification, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) image guided radiation therapy (IGRT) is used (with motion management functionality if required) to implement a stereotactic body radiation therapy plan at a level described in item 15920; and (c) radiation field positioning requires accurate dose delivery to the target; and (d) image decisions and actions are documented in the patient s record Applicable once per day	$1,366.30
15946	Megavoltage treatment level 5 Specialised radiation therapy treatment and verification, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) a specialised technique is used to implement a treatment plan with general anaesthetic or sedation supervised by an anaesthetist Applicable once per plan per day	$1,571.30
15948	Megavoltage treatment level 5Specialised radiation therapy treatment and verification, if: (a) the treatment is delivered using a device that is included in the Australian Register of Therapeutic Goods; and (b) a specialised technique, such as total skin electron therapy (TSE) or total body irradiation (TBI), is used to implement a treatment plan described in item 15926 Applicable up to twice per day	$1,571.30

Item No.	Description	Max Fee (excl. GST)
	Kilovoltage	
15950	Kilovoltage planning Simple complexity single field radiation therapy simulation and dosimetry for treatment planning without imaging for field setting, if: (a) both of the following apply in relation to the simulation: (i) localisation is based on clinical mark up and image based simulation is not required; (ii) patient set up and immobilisation techniques are suitable for two dimensional radiation therapy treatment, with wide margins and allowance for movement; and (b) all of the following apply in relation to the dosimetry: (i) the planning process is required to deliver a prescribed dose to a point, either at depth or on the surface of the patient; (ii) based on review and assessment by a radiation oncologist, the planning process does not require the differential of dose between target, organs at risk and normal tissue dose; (iii) delineation of structures is not possible or required, and field borders will delineate the treatment volume; (iv) doses are calculated in reference to a point, either at depth or on the surface of the patient, from tables, charts or data from a treatment planning system Applicable once per course of treatment	$352.70
15952	Delivery of kilovoltage radiation therapy (50 kV to 500 kV range) to one anatomical site (excluding orbital structures where there is placement of an internal eye shield)	$94.90
15954	Delivery of kilovoltage radiation therapy (50 kV to 500 kV range) to each additional anatomical site following delivery to one anatomical site treated under item 15952 (excluding orbital structures where there is placement of an internal eye shield)	$38.10
15956	Delivery of kilovoltage radiation therapy (50 kV to 500 kV range) to orbital structures where there is placement of an internal eye shield	$116.80
	Brachytherapy Post 1 July 2024	
15958	Simple placement or insertion of any of the following kinds of brachytherapy device, without image guidance: (a) intracavitary vaginal cylinder, vaginal ovoids, vaginal ring or vaginal mould; (b) surface mould or applicator, with catheters fixed to or embedded into mould or applicator, on external surface of body; including the removal of applicators, catheters or needles	$184.20
15960	Complex construction and manufacture of a personalised brachytherapy applicator or mould, derived from three-dimensional image volume datasets, including the removal of applicators, catheters or needles	$254.10
15962	Complex insertion of any of the following kinds of brachytherapy device, with image guidance and if a radiation oncologist is in attendance at the initiation of the service: (a) intrauterine tubes with or without ovoids, ring or cylinder; (b) endocavity applicators; (c) intraluminal catheters for treatment of bronchus, trachea, oesophagus, nasopharynx, bile duct; (d) endovascular catheters for treatment of vessels; including the removal of applicators, catheters or needles (Anaes.)	$552.40
15964	Complex insertion and removal of hybrid intracavitary and interstitial brachytherapy applicators, or intracavitary and multi catheter applicators, with image guidance and if a radiation oncologist is in attendance at the initiation of the service (Anaes.)	$736.70
15966	Complex insertion of any of the following kinds of interstitial brachytherapy implants not requiring surgical exposure, with image guidance, and if a radiation oncologist is in attendance during the service: (a) catheters or needles for temporary implants; (b) radioactive sources for permanent implants; (c) breast applicators, single channel and multi channel strut devices; including the removal of applicators, catheters or needles (Anaes.)	$920.80
15968	Complex insertion of any of the following interstitial brachytherapy implants requiring surgical exposure (other than a service to which item 15900 applies), if a radiation oncologist is in attendance at the initiation of the service: (a) catheters, needles or applicators to a region requiring surgical exposure; (b) radioactive sources for permanent implants; (c) surface moulds during intraoperative brachytherapy; (d) plastic catheters or stainless steel needles, requiring surgical exposure; including implantation and removal of applicators, catheters or needles (Anaes.)	$1,443.30
15970	Simple level dosimetry for brachytherapy plans prescribed to surface or depth from catheter and library plans, if: (a) the planning process is required to deliver a prescribed dose to a three dimensional volume, and relative to a single line or multiple channel delivery applicator; and (b) the planning process does not require the differential of dose between the target, organs at risk and normal tissue dose; and (c) delineation of structures is not required; and (d) dose calculations are performed in reference to the surface or a point at depth (two dimensional plan) from tables, charts or data from a treatment planning system library plan	$239.50
15972	Simple level dosimetry re planning of an initial brachytherapy plan described in item 15970 if treatment adjustments to that initial plan are inadequate to satisfy treatment protocol requirements	$119.80
15974	Intermediate level dosimetry calculated on a volumetric dataset for intracavitary or intraluminal or endocavity applicators, for brachytherapy plans that have three dimensional image datasets acquired as part of simulation, if: (a) the planning process is required to deliver the prescribed dose to a three dimensional volume, and relative to multiple line for channel delivery applicators (excluding interstitial catheters and needles and multi catheter devices); and (b) based on review and assessment by a radiation oncologist, the planning process requires the differential of dose between target, organs at risk and normal tissue dose using avoidance strategies (which include placement of sources and/or dwell times or tissue packing); and (c) delineation of structures is required as part of the planning process to produce a dose volume histogram integral to the avoidance strategies; and (d) dose calculations are performed on a personalised basis, which must include three dimensional dose calculation to target and organ at risk volumes; and (e) dose calculations and the dose volume histogram are approved and recorded with the plan	$1,605.90

Item No.	Description	Max Fee (excl. GST)
15976	Intermediate level dosimetry re planning of an initial brachytherapy plan described in item 15974 if treatment adjustments to that initial plan are inadequate to satisfy treatment protocol requirements	$803.10
15978	Complex level dosimetry for brachytherapy plans that contain multiple needles, catheters or radiation sources, calculated on the three dimensional volumetric dataset, if: (a) the planning process is required to deliver a prescribed dose to a target volume relative to multiple channel delivery applicators, needles or catheters or radiation sources; and (b) based on review and assessment by a radiation oncologist, the planning process requires the differential of doses between the target, organs at risk and normal tissue dose using avoidance strategies (which include the placement of sources and/or dwell times or tissue packing; and (c) delineation of structures is required as part of the planning process, in order to produce a dose volume histogram to review and assess the plan; and (d) dose calculations are performed on a personalised basis, which must include three dimensional dose calculation to target and organ at risk volumes; and (e) dose calculations and the dose volume histogram are approved and recorded with the plan	$1,866.30
15980	Complex level dosimetry re planning of an initial brachytherapy plan described in item 15978 if treatment adjustments to the initial plan are inadequate to satisfy treatment protocol requirements	$933.30
15982	Brachytherapy treatment, if: (a) the service is performed by radiation therapists and medical physicists; and (b) a radiation oncologist is in attendance during the service; and (c) the treatment is to implement a brachytherapy treatment plan described in any of items 15970, 15972, 15974, 15976, 15978 and 15980	$699.80
15984	Verification of position of brachytherapy applicators, needles, catheters or radioactive sources, if: (a) a two dimensional or three dimensional volumetric image set, or a validated in vivo dosimetry measurement, is required to facilitate an adjustment to the applicators, needles, catheters or dosimetry plan; and (b) decisions using the acquired images are based on action algorithms and enacted immediately prior to, or during, treatment, where treatment is preceded by manipulation or adjustment of delivery applicator or adjustment of the dosimetry plan; and (c) the service is associated with a service to which any of the following items apply: (i) items 15958 to 15968; (ii) item 15982	$257.80
GROUP T3—THERAPEUTIC NUCLEAR MEDICINE		
16003	Intra-cavitary administration of a therapeutic dose of Yttrium 90 (not including preliminary paracentesis and other than a service to which item 35404, 35406 or 35408 applies or a service associated with selective internal radiation therapy) (Anaes.)	$1,613.20
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	$1,236.80
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	$877.30
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	$759.30
16015	Administration of Strontium 89 for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient s disease and either: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.	$9,256.40
16018	Administration of 153 Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient s disease, and: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.	$4,934.20
GROUP T4—OBSTETRICS		
16400	Antenatal service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, applicable 10 times for a pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner; and (d) the service is not provided for an admitted patient of a hospital or approved day facility	$63.50
16401	Professional attendance at consulting rooms or a hospital by a specialist in the practice of the specialist's specialty of obstetrics after referral of the patient to the specialist initial attendance in a single course of treatment	$196.30
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of the specialist's specialty of obstetrics after referral of the patient to the specialist an attendance after the initial attendance in a single course of treatment	$102.00
16406	Antenatal professional attendance by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife Applicable once for a pregnancy	$307.70
16407	Postnatal professional attendance (other than a service to which any other item applies) if the attendance: (a) is by an obstetrician or general practitioner; and (b) is in hospital or at consulting rooms; and (c) is between 4 and 8 weeks after the birth; and (d) lasts at least 20 minutes; and (e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Payable once only for a pregnancy	$159.80

Item No.	Description	Max Fee (excl. GST)
16408	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance: (a) is by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Payable once only for a pregnancy	$118.90
16500	Antenatal attendance	$105.40
16501	External cephalic version for breech presentation, after 36 weeks, if no contraindication exists, in a unit with facilities for caesarean section, including pre and post version CTG, with or without tocolysis, other than a service to which items 55718 to 55728 and 55768 to 55774 apply chargeable whether or not the version is successful and limited to a maximum of 2 ECVs per pregnancy	$327.40
16502	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital a professional attendance that is not a routine antenatal attendance, applicable once per day	$108.20
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of an attendance that is not a routine antenatal attendance	$111.70
16508	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, applicable once per day	$108.00
16509	Pre eclampsia, eclampsia or antepartum haemorrhage, treatment of professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance	$111.90
16511	Cervix, purse string ligation of (Anaes.)	$523.60
16512	Cervix, removal of purse string ligature of (Anaes.)	$150.80
16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)	$85.60
16515	Management of vaginal birth as an independent procedure, if the patient s care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)	$1,407.70
16518	Management of labour, incomplete, if the patient s care has been transferred to another medical practitioner for completion of the birth (Anaes.)	$1,091.80
16519	Management of labour and birth by any means (including Caesarean section) including post partum care for 5 days (Anaes.)	$1,876.20
16520	Caesarean section and post operative care for 7 days, if the patient s care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (H) (Anaes.)	$2,028.20

Item No.	Description	Max Fee (excl. GST)
16522	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days: (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: (i) of greater than 200ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth where there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1cm/hr in the active phase of labour (after 3cm cervical dilatation and effacement until full dilatation of the cervix); (i) acute fetal compromise evidenced by: (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm); (iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90mm Hg associated with: (i) at least 2+ proteinuria on urinalysis; or (ii) protein-creatinine ratio greater than 30mg/mmol; or (iii) platelet count less than 150 x 109/L; or (iv) uric acid greater than 0.36mmol/L; (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring; (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by: (i) the patient requiring hospitalisation; or (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices; (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (xi) thyrotoxicosis requiring medication; (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium; (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation; (xiv) HIV, hepatitis B or hepatitis C carrier status positive; (xv) red cell or platelet iso-immunisation; (xvi) cancer with metastatic disease; (xvii) illicit drug misuse during pregnancy (Anaes.)	$3,646.10
16527	Management of vaginal birth, if the patient s care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth Applicable once for a pregnancy (Anaes.)	$1,139.40
16528	Caesarean section and post operative care for 7 days, if the patient s care has been transferred by a participating midwife for management of the birth Applicable once for a pregnancy (H) (Anaes.)	$1,448.50
16530	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)	$856.30
16531	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)	$1,712.70
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	$235.20
16534	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	$235.20
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 (H) (Anaes.)	$517.20
16567	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (H) (Anaes.)	$760.40
16570	Acute inversion of the uterus, vaginal correction of, as an independent procedure (H) (Anaes.)	$933.40
16571	Cervix, repair of extensive laceration or lacerations (Anaes.)	$757.90
16573	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (H) (Anaes.)	$585.00
16600	Amniocentesis, diagnostic	$160.50
16603	Chorionic villus sampling, by any route	$289.00
16606	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)	$566.80
16609	Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (H) (Anaes.)	$1,155.50

Item No.	Description	Max Fee (excl. GST)
16612	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)	$909.00
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 (H) (Anaes.)	$484.50
16618	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500ml being aspirated (H)	$491.10
16621	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios (H)	$484.50
16624	Fetal fluid filled cavity, drainage of (H)	$697.00
16627	Feto amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis (H)	$1,418.70
GROUP T6—ANAESTHETICS		
	Anaesthesia consultations	
17610	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION (Professional attendance by a medical practitioner in the practice of ANAESTHESIA) - a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system) - AND of not more than 15 minutes s duration, not being a service associated with a service to which items 2801 - 3000 apply	$175.60
17615	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies	$349.30
17620	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	$500.90
17625	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes - and of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	$614.40
17640	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia) (Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her) - a BRIEF consultation involving a short history and limited examination - AND of not more than 15 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	$181.70
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.	$361.60
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	$505.30
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.	$633.40
17680	ANAESTHETIST, CONSULTATION, OTHER (Professional attendance by an anaesthetist in the practice of ANAESTHESIA) - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply.	$360.50
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.	$171.00

Item No.	Description	Max Fee (excl. GST)
GROUP T7—REGIONAL OR FIELD NERVE BLOCKS		
18213	Intravenous regional anaesthesia of limb by retrograde perfusion of local anaesthetic agent	$209.40
18216	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (H) (Anaes.)	$272.00
18219	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (H) (Anaes.)	$577.20
18222	Continuous infusion or injection by catheter of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is 15 minutes or less	$95.60
18225	Continuous infusion or injection by catheter of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is more than 15 minutes	$133.70
18226	Intrathecal, combined spinal epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner for a patient in labour, if the service is provided between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (H)	$663.00
18227	Intrathecal, combined spinal epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by a medical practitioner extends beyond the first hour for a patient in labour, if the service is provided between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (H)	$871.10
18228	Interpleural block, initial injection or commencement of infusion of a therapeutic substance, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$162.80
18230	Intrathecal or epidural injection of neurolytic substance (not contrast agent) by any route, including transforaminal route (Anaes.)	$567.40
18232	Intrathecal or epidural injection (including translaminar and transforaminal approaches) of therapeutic substance or substances (anaesthetic, steroid or chemotherapeutic agents): (a) other than a service to which another item in this Group applies; and (b) not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	$448.90
18233	Epidural injection of blood for blood patch (Anaes.)	$454.70
18234	Trigeminal nerve, primary branch (ophthalmic, maxillary or mandibular branches, excluding infraorbital nerve), injection of an anaesthetic agent or steroid, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.)	$282.10
18236	Trigeminal nerve, peripheral branch (including infraorbital nerve), injection of an anaesthetic agent, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.)	$148.40
18238	Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$88.40
18240	Retrobulbar or peribulbar injection of an anaesthetic agent	$211.20
18242	Greater occipital nerve, injection of an anaesthetic agent (Anaes.)	$84.00
18244	Vagus nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$253.20
18248	Phrenic nerve, injection of an anaesthetic agent	$199.60
18250	Spinal accessory nerve, injection of an anaesthetic agent	$170.40
18252	Cervical plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$239.80
18254	Brachial plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$260.70
18256	Suprascapular nerve, injection of an anaesthetic agent	$150.10
18258	Intercostal nerve (single), injection of an anaesthetic agent	$149.20

Item No.	Description	Max Fee (excl. GST)
18260	Intercostal nerves (multiple), injection of an anaesthetic agent	$214.30
18262	Ilio inguinal, iliohypogastric or genitofemoral nerves, one or more of, injections of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	$171.10
18264	Pudendal nerve or dorsal nerve (or both), injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$233.80
18266	Ulnar, radial or median nerve, main trunk of, one or more of, injections of an anaesthetic agent, not being associated with a brachial plexus block, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$151.80
18268	Obturator nerve, injection of an anaesthetic agent	$203.80
18270	Femoral nerve, injection of an anaesthetic agent	$335.50
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent	$192.30
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels)	$287.30
18278	Sciatic nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	$201.70
18280	Sphenopalatine ganglion, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	$297.80
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure (H)	$307.30
18284	Cervical or thoracic sympathetic chain, injection of an anaesthetic agent (H) (Anaes.)	$337.50
18286	Lumbar or pelvic sympathetic chain, injection of an anaesthetic agent (H) (Anaes.)	$337.50
18288	Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (H) (Anaes.)	$331.80
18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent under image guidance, other than a service associated with the injection of botulinum toxin (Anaes.)	$584.90
18292	Nerve branch, destruction by a neurolytic agent under image guidance, other than a service to which another item in this Group applies or a service associated with the injection of botulinum toxin except a service to which item 18354 applies (Anaes.)	$282.60
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent under image guidance (H) (Anaes.)	$419.00
18296	Lumbar or pelvic sympathetic chain, destruction by a neurolytic agent under image guidance (H) (Anaes.)	$333.60
18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner	$131.40
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	$411.90
GROUP T11—BOTULINUM TOXIN INJECTIONS		
18350	Botulinum toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day	$294.20
18351	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day	$297.90
18353	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day	$584.90
18354	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity from cerebral palsy, if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)	$297.30

Item No.	Description	Max Fee (excl. GST)
18355	IncobotulinumtoxinA (Xeomin), injection of, for the treatment of chronic sialorrhea in a patient who is at least 2 years of age, if the condition is due to a neurological or neurodevelopmental disorder, including all such injections on any one day (Anaes.)	$218.50
18360	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), or Clostridium Botulinum Type A Toxin Haemagglutinin Complex (Dysport), injection of, for the treatment of moderate to severe focal spasticity, if: (a) the patient is at least 18 years of age; and (b) the spasticity is associated with a previously diagnosed neurological disorder; and (c) treatment is provided as: (i) second line therapy when standard treatment for the conditions has failed; or (ii) an adjunct to physical therapy; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and (e) the treatment is not provided on the same occasion as a service mentioned in item 18365	$292.50
18361	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)	$286.90
18362	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if: (a) the patient is at least 12 years of age; and (b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and (c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and (d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.)	$571.40
18365	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following an acute event, if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment	$293.60
18366	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.)	$349.60
18368	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day	$625.30
18369	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	$106.20
18370	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)	$106.60
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.)	$290.80
18374	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	$290.80
18375	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with: (i) multiple sclerosis; or (ii) spinal cord injury; or (iii) spina bifida and who is at least 18 years of age; and (b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and (c) the patient is willing and able to self-catheterise; and (d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and (e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.)	$509.30

Item No.	Description	Max Fee (excl. GST)
18377	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if: (a) the patient is at least 18 years of age; and (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and (c) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with For each patient-applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration)	$276.50
18379	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to idiopathic overactive bladder in a patient: and (b) the patient is at least 18 years of age; and (c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti- cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin; and (d) the patient is willing and able to self-catheterise; and (e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (H) (Anaes.)	$543.40
GROUP T10—RELATIVE VALUE GUIDE FOR ANAESTHESIA—WORKCOVER BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE		
	Head	
20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)	$513.30
20102	Initiation of the management of anaesthesia for plastic repair of cleft lip (H) (6 basic units)	$616.00
20104	Initiation of the management of anaesthesia for electroconvulsive therapy (H) (4 basic units)	$410.70
20120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)	$513.30
20124	Initiation of the management of anaesthesia for otoscopy (H) (4 basic units)	$410.70
20140	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units)	$513.30
20142	Initiation of the management of anaesthesia for lens surgery (H) (5 basic units)	$513.30
20143	Initiation of the management of anaesthesia for retinal surgery (H) (6 basic units)	$616.00
20144	Initiation of the management of anaesthesia for corneal transplant (H) (7 basic units)	$718.70
20145	Initiation of the management of anaesthesia for vitrectomy (H) (7 basic units)	$718.70
20146	Initiation of the management of anaesthesia for biopsy of conjunctiva (H) (5 basic units)	$513.30
20147	Initiation of the management of anaesthesia for squint repair (H) (6 basic units)	$616.00
20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)	$410.70
20160	Initiation of the management of anaesthesia for intranasal procedures on nose or accessory sinuses, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (H) (7 basic units)	$718.70
20164	Initiation of the management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses (H) (4 basic units)	$410.70
20170	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units)	$616.00
20172	Initiation of the management of anaesthesia for repair of cleft palate (H) (7 basic units)	$718.70
20174	Initiation of the management of anaesthesia for excision of retropharyngeal tumour (H) (9 basic units)	$924.00
20176	Initiation of the management of anaesthesia for radical intraoral surgery (H) (10 basic units)	$1,026.70
20190	Initiation of the management of anaesthesia for procedures on facial bones, other than a service to which another item in this Subgroup applies (H) (5 basic units)	$513.30
20192	Initiation of the management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (H) (10 basic units)	$1,026.70
20210	Initiation of the management of anaesthesia for intracranial procedures, other than a service to which another item in this Subgroup applies (H) (15 basic units)	$1,539.90
20212	Initiation of the management of anaesthesia for subdural taps (H) (5 basic units)	$513.30

Item No.	Description	Max Fee (excl. GST)
20214	Initiation of the management of anaesthesia for burr holes of the cranium (H) (9 basic units)	$924.00
20216	Initiation of the management of anaesthesia for intracranial vascular procedures, including those for aneurysms or arterio venous abnormalities (H) (20 basic units)	$2,053.20
20220	Initiation of the management of anaesthesia for spinal fluid shunt procedures (H) (10 basic units)	$1,026.70
20222	Initiation of the management of anaesthesia for ablation of an intracranial nerve (H) (6 basic units)	$616.00
20225	Initiation of the management of anaesthesia for all cranial bone procedures (H) (12 basic units)	$1,231.90
20230	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the head or face (H) (12 basic units)	$1,231.90
	Neck	
20300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units)	$513.30
20305	Initiation of the management of anaesthesia for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis, causing life threatening airway obstruction (H) (15 basic units)	$1,539.90
20320	Initiation of the management of anaesthesia for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
20321	Initiation of the management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (H) (10 basic units)	$1,026.70
20330	Initiation of the management of anaesthesia for laser surgery to the airway (excluding nose and mouth) (H) (8 basic units)	$821.30
20350	Initiation of the management of anaesthesia for procedures on major vessels of neck, other than a service to which another item in this Subgroup applies (H) (10 basic units)	$1,026.70
20352	Initiation of the management of anaesthesia for simple ligation of major vessels of neck (H) (5 basic units)	$513.30
20355	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the neck (H) (12 basic units)	$1,231.90
	Thorax	
20400	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units)	$308.00
20401	Initiation of the management of anaesthesia for procedures on the breast, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
20402	Initiation of management of anaesthesia for reconstructive procedures on breast, including implant reconstruction and exchange (H) (5 basic units)	$513.30
20403	Initiation of management of anaesthesia for axillary dissection or sentinel node biopsy (H) (5 basic units)	$513.30
20404	Initiation of the management of anaesthesia for mastectomy (H) (6 basic units)	$616.00
20405	Initiation of the management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps (H) (8 basic units)	$821.30
20406	Initiation of the management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection (H) (13 basic units)	$1,334.50
20410	Initiation of the management of anaesthesia for electrical conversion of arrhythmias (H) (4 basic units)	$410.70
20420	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units)	$513.30
20440	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the sternum (H) (4 basic units)	$410.70
20450	Initiation of the management of anaesthesia for procedures on clavicle, scapula or sternum, other than a service to which another item in this Subgroup applies (H) (5 basic units)	$513.30
20452	Initiation of the management of anaesthesia for radical surgery on clavicle, scapula or sternum (H) (6 basic units)	$616.00
20470	Initiation of the management of anaesthesia for partial rib resection, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
20472	Initiation of the management of anaesthesia for thoracoplasty (H) (10 basic units)	$1,026.70
20474	Initiation of the management of anaesthesia for radical procedures on chest wall (H) (13 basic units)	$1,334.50

Item No.	Description	Max Fee (excl. GST)
20475	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax (H) (10 basic units)	$1,026.70
	Intrathoracic	
20500	Initiation of the management of anaesthesia for open procedures on the oesophagus (H) (15 basic units)	$1,539.90
20520	INITIATION OF MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units)	$616.00
20522	Initiation of the management of anaesthesia for needle biopsy of pleura (H) (4 basic units)	$410.70
20524	Initiation of the management of anaesthesia for pneumocentesis (H) (4 basic units)	$410.70
20526	Initiation of the management of anaesthesia for thoracoscopy (H) (10 basic units)	$1,026.70
20528	Initiation of the management of anaesthesia for mediastinoscopy (H) (8 basic units)	$821.30
20540	Initiation of the management of anaesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, other than a service to which another item in this Subgroup applies (H) (13 basic units)	$1,334.50
20542	Initiation of the management of anaesthesia for pulmonary decortication (H) (15 basic units)	$1,539.90
20546	Initiation of the management of anaesthesia for pulmonary resection with thoracoplasty (H) (15 basic units)	$1,539.90
20548	Initiation of the management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi (H) (15 basic units)	$1,539.90
20560	Initiation of the management of anaesthesia for: (a) open procedures on the heart, pericardium or great vessels of the chest; or (b) percutaneous insertion of a valvular prosthesis (H) (20 basic units)	$2,053.20
	Spine and spinal cord	
20600	Initiation of the management of anaesthesia for procedures on cervical spine or spinal cord, or both, other than a service to which another item in this Subgroup applies (H) (10 basic units)	$1,026.70
20604	Initiation of the management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position (H) (13 basic units)	$1,334.50
20620	Initiation of the management of anaesthesia for procedures on thoracic spine or spinal cord, or both, other than a service to which another item in this Subgroup applies (H) (10 basic units)	$1,026.70
20622	Initiation of the management of anaesthesia for thoracolumbar sympathectomy (H) (13 basic units)	$1,334.50
20630	Initiation of the management of anaesthesia for procedures in lumbar region, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30
20632	Initiation of the management of anaesthesia for lumbar sympathectomy (H) (7 basic units)	$718.70
20634	Initiation of the management of anaesthesia for chemonucleolysis (H) (10 basic units)	$1,026.70
20670	Initiation of the management of anaesthesia for extensive spine or spinal cord procedures, or both (H) (13 basic units)	$1,334.50
20680	Initiation of the management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital (H) (3 basic units)	$308.00
20690	Initiation of the management of anaesthesia for percutaneous spinal procedures, other than a service to which another item in this Subgroup applies (H) (5 basic units)	$513.30
	Upper abdomen	
20700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units)	$308.00
20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)	$410.70
20703	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
20704	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (H) (10 basic units)	$1,026.70
20706	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, other than a service to which another item in this Subgroup applies (H) (7 basic units)	$718.70
20730	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)	$513.30

Item No.	Description	Max Fee (excl. GST)
20740	Initiation of the management of anaesthesia for upper gastrointestinal endoscopic procedures (H) (5 basic units)	$513.30
20745	Initiation of the management of anaesthesia for any of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography; (c) upper gastrointestinal endoscopic ultrasound; (d) percutaneous endoscopic gastrostomy; (e) upper gastrointestinal endoscopic mucosal resection of tumour (H) (7 basic units)	$718.70
20750	Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies (H) (5 basic units)	$513.30
20752	Initiation of the management of anaesthesia for repair of incisional hernia or wound dehiscence, or both (H) (6 basic units)	$616.00
20754	Initiation of the management of anaesthesia for procedures on an omphalocele (H) (7 basic units)	$718.70
20756	Initiation of the management of anaesthesia for transabdominal repair of diaphragmatic hernia (H) (9 basic units)	$924.00
20770	Initiation of the management of anaesthesia for procedures on major upper abdominal blood vessels (H) (15 basic units)	$1,539.90
20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in the upper abdomen, including any of the following: (a) open cholecystectomy; (b) gastrectomy; (c) laparoscopic assisted nephrectomy; (d) bowel shunts (H) (8 basic units)	$821.30
20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (H) (10 basic units)	$1,026.70
20792	Initiation of the management of anaesthesia for partial hepatectomy (excluding liver biopsy) (H) (13 basic units)	$1,334.50
20793	Initiation of the management of anaesthesia for extended or trisegmental hepatectomy (H) (15 basic units)	$1,539.90
20794	Initiation of the management of anaesthesia for pancreatectomy, partial or total (H) (12 basic units)	$1,231.90
20798	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the upper abdomen (H) (10 basic units)	$1,026.70
20799	Initiation of the management of anaesthesia for percutaneous procedures on an intra abdominal organ in the upper abdomen (H) (6 basic units)	$616.00
	Lower abdomen	
20800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)	$308.00
20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)	$513.30
20803	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
20804	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (H) (10 basic units)	$1,026.70
20806	Initiation of the management of anaesthesia for laparoscopic procedures in the lower abdomen (H) (7 basic units)	$718.70
20810	Initiation of the management of anaesthesia for lower intestinal endoscopic procedures (H) (4 basic units)	$410.70
20815	Initiation of the management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract (H) (6 basic units)	$616.00
20820	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units)	$513.30
20830	Initiation of the management of anaesthesia for hernia repairs in lower abdomen, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
20832	Initiation of the management of anaesthesia for repair of incisional herniae or wound dehiscence, or both, of the lower abdomen (H) (6 basic units)	$616.00
20840	Initiation of the management of anaesthesia for all open procedures within the peritoneal cavity in the lower abdomen, including appendicectomy, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
20841	Initiation of the management of anaesthesia for bowel resection, including laparoscopic bowel resection, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30
20842	Initiation of the management of anaesthesia for amniocentesis (H) (4 basic units)	$410.70
20844	Initiation of the management of anaesthesia for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (H) (10 basic units)	$1,026.70

Item No.	Description	Max Fee (excl. GST)
20845	Initiation of the management of anaesthesia for radical prostatectomy (H) (10 basic units)	$1,026.70
20846	Initiation of the management of anaesthesia for radical hysterectomy (H) (10 basic units)	$1,026.70
20847	Initiation of the management of anaesthesia for ovarian malignancy (H) (10 basic units)	$1,026.70
20848	Initiation of the management of anaesthesia for pelvic exenteration (H) (10 basic units)	$1,026.70
20850	Initiation of the management of anaesthesia for caesarean section (H) (12 basic units)	$1,231.90
20855	Initiation of the management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of birth (H) (15 basic units)	$1,539.90
20860	Initiation of the management of anaesthesia for extraperitoneal procedures in lower abdomen, including those on the urinary tract, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
20862	Initiation of the management of anaesthesia for renal procedures, including upper one third of ureter (H) (7 basic units)	$718.70
20863	Initiation of the management of anaesthesia for nephrectomy (H) (10 basic units)	$1,026.70
20864	Initiation of the management of anaesthesia for total cystectomy (H) (10 basic units)	$1,026.70
20866	Initiation of the management of anaesthesia for adrenalectomy (H) (10 basic units)	$1,026.70
20867	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the lower abdomen (H) (10 basic units)	$1,026.70
20868	Initiation of the management of anaesthesia for renal transplantation (donor or recipient) (H) (10 basic units)	$1,026.70
20880	Initiation of the management of anaesthesia for procedures on major lower abdominal vessels, other than a service to which another item in this Subgroup applies (H) (15 basic units)	$1,539.90
20882	Initiation of the management of anaesthesia for inferior vena cava ligation (H) (10 basic units)	$1,026.70
20884	Initiation of the management of anaesthesia for percutaneous umbrella insertion (H) (5 basic units)	$513.30
20886	Initiation of the management of anaesthesia for percutaneous procedures on an intra abdominal organ in the lower abdomen (H) (6 basic units)	$616.00
	Perineum	
20900	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the perineum not being a service to which another item in this Subgroup applies (3 basic units)	$308.00
20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (H) (4 basic units)	$410.70
20904	Initiation of the management of anaesthesia for radical perineal procedures, including radical perineal prostatectomy or radical vulvectomy (H) (7 basic units)	$718.70
20905	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the perineum (H) (10 basic units)	$1,026.70
20906	Initiation of the management of anaesthesia for vulvectomy (H) (4 basic units)	$410.70
20910	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units)	$410.70
20911	Initiation of the management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures (H) (5 basic units)	$513.30
20912	Initiation of the management of anaesthesia for transurethral resection of bladder tumour or tumours (H) (5 basic units)	$513.30
20914	Initiation of the management of anaesthesia for transurethral resection of prostate (H) (7 basic units)	$718.70
20916	Initiation of the management of anaesthesia for bleeding post-transurethral resection (H) (7 basic units)	$718.70
20920	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units)	$410.70
20924	Initiation of the management of anaesthesia for procedures on undescended testis, unilateral or bilateral (H) (4 basic units)	$410.70
20926	Initiation of the management of anaesthesia for radical orchidectomy, inguinal approach (H) (4 basic units)	$410.70
20928	Initiation of the management of anaesthesia for radical orchidectomy, abdominal approach (H) (6 basic units)	$616.00
20930	Initiation of the management of anaesthesia for orchiopexy, unilateral or bilateral (H) (4 basic units)	$410.70
20932	Initiation of the management of anaesthesia for complete amputation of penis (H) (4 basic units)	$410.70
20934	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy (H) (6 basic units)	$616.00

Item No.	Description	Max Fee (excl. GST)
20936	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (H) (8 basic units)	$821.30
20938	Initiation of the management of anaesthesia for insertion of penile prosthesis (H) (4 basic units)	$410.70
20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units)	$410.70
20942	Initiation of the management of anaesthesia for vaginal procedures (including repair operations and urinary incontinence procedures) (H) (5 basic units)	$513.30
20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units)	$410.70
20944	Initiation of the management of anaesthesia for vaginal hysterectomy (H) (6 basic units)	$616.00
20946	Initiation of the management of anaesthesia for vaginal birth (H) (8 basic units)	$821.30
20948	Initiation of the management of anaesthesia for purse string ligation of cervix, or removal of purse string ligature, or removal of purse string ligature (H) (4 basic units)	$410.70
20950	Initiation of the management of anaesthesia for culdoscopy (H) (5 basic units)	$513.30
20952	Initiation of the management of anaesthesia for hysteroscopy (H) (4 basic units)	$410.70
20954	Initiation of the management of anaesthesia for correction of inverted uterus (H) (10 basic units)	$1,026.70
20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units)	$410.70
20958	Initiation of the management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following birth (H) (5 basic units)	$513.30
20960	Initiation of the management of anaesthesia for vaginal procedures in the management of post-partum haemorrhage, if the blood loss isgreater than 500ml (H) (7 basic units)	$718.70
	Pelvis(except hip)	
21100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units)	$308.00
21110	Initiation of the management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (H) (5 basic units)	$513.30
21112	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest (H) (4 basic units)	$410.70
21114	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest (H) (5 basic units)	$513.30
21116	Initiation of the management of anaesthesia for percutaneous bone marrow harvesting from the pelvis (H) (6 basic units)	$616.00
21120	Initiation of the management of anaesthesia for procedures on the bony pelvis (H) (6 basic units)	$616.00
21130	Initiation of the management of anaesthesia for body cast application or revision, when performed in the operating theatre of a hospital (H) (3 basic units)	$308.00
21140	Initiation of the management of anaesthesia for interpelviabdominal (hindquarter) amputation (H) (15 basic units)	$1,539.90
21150	Initiation of the management of anaesthesia for radical procedures for tumour of the pelvis, except hindquarter amputation (H) (10 basic units)	$1,026.70
21155	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior pelvis (H) (10 basic units)	$1,026.70
21160	Initiation of the management of anaesthesia for closed procedures involving symphysis pubis or sacroiliac joint, when performed in the operating theatre of a hospital (H) (4 basic units)	$410.70
21170	Initiation of the management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint (H) (8 basic units)	$821.30
	Upper leg(except knee)	
21195	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units)	$308.00
21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units)	$410.70
21200	Initiation of the management of anaesthesia for closed procedures involving hip joint, when performed in the operating theatre of a hospital (H) (4 basic units)	$410.70

Item No.	Description	Max Fee (excl. GST)
21202	Initiation of the management of anaesthesia for arthroscopic procedures of the hip joint (H) (4 basic units)	$410.70
21210	Initiation of the management of anaesthesia for open procedures involving hip joint, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
21212	Initiation of the management of anaesthesia for hip disarticulation (H) (10 basic units)	$1,026.70
21214	Initiation of management of anaesthesia for primary total hip replacement. (H) (10 basic units)	$1,026.70
21215	Initiation of management of anaesthesia for revision total hip replacement (H) (15 basic units)	$1,539.90
21216	Initiation of the management of anaesthesia for bilateral total hip replacement (H) (14 basic units)	$1,437.20
21220	Initiation of the management of anaesthesia for closed procedures involving upper two-thirds of femur, when performed in the operating theatre of a hospital (H) (4 basic units)	$410.70
21230	Initiation of the management of anaesthesia for open procedures involving upper two-thirds of femur, other than a service to which another item in this Subgroup applies (H) (6 basic units)	$616.00
21232	Initiation of the management of anaesthesia for above knee amputation (H) (5 basic units)	$513.30
21234	Initiation of the management of anaesthesia for radical resection of the upper two thirds of femur (H) (8 basic units)	$821.30
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units)	$410.70
21270	Initiation of the management of anaesthesia for procedures involving arteries of upper leg, including bypass graft, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30
21272	Initiation of the management of anaesthesia for femoral artery ligation (H) (4 basic units)	$410.70
21274	Initiation of the management of anaesthesia for femoral artery embolectomy (H) (6 basic units)	$616.00
21275	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper leg (H) (10 basic units)	$1,026.70
21280	Initiation of the management of anaesthesia for microsurgical reimplantation of upper leg (H) (15 basic units)	$1,539.90
	Knee and popliteal area	
21300	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the knee or popliteal area, or both (H) (3 basic units)	$308.00
21321	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee or popliteal area, or both (H) (4 basic units)	$410.70
21340	Initiation of the management of anaesthesia for closed procedures on lower one third of femur, when performed in the operating theatre of a hospital (H) (4 basic units)	$410.70
21360	Initiation of the management of anaesthesia for open procedures on lower one third of femur (H) (5 basic units)	$513.30
21380	Initiation of the management of anaesthesia for closed procedures on knee joint when performed in the operating theatre of a hospital (H) (3 basic units)	$308.00
21382	Initiation of the management of anaesthesia for arthroscopic procedures of knee joint (H) (4 basic units)	$410.70
21390	Initiation of the management of anaesthesia for closed procedures on upper ends of tibia, fibula or patella, or any of them, when performed in the operating theatre of a hospital (H) (3 basic units)	$308.00
21392	Initiation of the management of anaesthesia for open procedures on upper ends of tibia, fibula or patella, or any of them (H) (4 basic units)	$410.70
21400	Initiation of the management of anaesthesia for open procedures on knee joint, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
21402	Initiation of the management of anaesthesia for knee replacement (H) (7 basic units)	$718.70
21403	Initiation of the management of anaesthesia for bilateral knee replacement (H) (10 basic units)	$1,026.70
21404	Initiation of the management of anaesthesia for disarticulation of knee (H) (5 basic units)	$513.30
21420	Initiation of the management of anaesthesia for cast application, removal or repair, involving knee joint, undertaken in a hospital (H) (3 basic units)	$308.00
21430	Initiation of the management of anaesthesia for procedures on veins of knee or popliteal area, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
21432	Initiation of the management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area (H) (5 basic units)	$513.30
21440	Initiation of the management of anaesthesia for procedures on arteries of knee or popliteal area, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30

Item No.	Description	Max Fee (excl. GST)
21445	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the knee or popliteal area (H) (10 basic units)	$1,026.70
	Lower leg(below knee)	
21460	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units)	$308.00
21461	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units)	$410.70
21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units)	$308.00
21464	Initiation of the management of anaesthesia for arthroscopic procedure of ankle joint (H) (4 basic units)	$410.70
21472	Initiation of the management of anaesthesia for repair of Achilles tendon (H) (5 basic units)	$513.30
21474	Initiation of the management of anaesthesia for gastrocnemius recession (H) (5 basic units)	$513.30
21480	Initiation of the management of anaesthesia for open procedures on bones of lower leg, ankle or foot, including amputation, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
21482	Initiation of the management of anaesthesia for radical resection of bone involving lower leg, ankle or foot (H) (5 basic units)	$513.30
21484	Initiation of the management of anaesthesia for osteotomy or osteoplasty of tibia or fibula (H) (5 basic units)	$513.30
21486	Initiation of the management of anaesthesia for total ankle replacement (H) (7 basic units)	$718.70
21490	Initiation of the management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital (H) (3 basic units)	$308.00
21500	Initiation of the management of anaesthesia for procedures on arteries of lower leg, including bypass graft, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30
21502	Initiation of the management of anaesthesia for embolectomy of the lower leg (H) (6 basic units)	$616.00
21520	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units)	$410.70
21522	Initiation of the management of anaesthesia for venous thrombectomy of the lower leg (H) (5 basic units)	$513.30
21530	Initiation of the management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot (H) (15 basic units)	$1,539.90
21532	Initiation of the management of anaesthesia for microsurgical reimplantation of toe (H) (8 basic units)	$821.30
21535	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the lower leg (H) (10 basic units)	$1,026.70
	Shoulder and axilla	
21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)	$308.00
21610	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla, including axillary dissection (H) (5 basic units)	$513.30
21620	Initiation of the 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 (H) (4 basic units)	$410.70
21622	Initiation of the management of anaesthesia for arthroscopic procedures of shoulder joint (H) (5 basic units)	$513.30
21630	Initiation of the management of anaesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular jointor shoulder joint, other than a service to which another item in this Subgroup applies (H) (5 basic units)	$513.30
21632	Initiation of the management of anaesthesia for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (H) (6 basic units)	$616.00
21634	Initiation of the management of anaesthesia for shoulder disarticulation (H) (9 basic units)	$924.00
21636	Initiation of the management of anaesthesia for interthoracoscapular (forequarter) amputation (H) (15 basic units)	$1,539.90
21638	Initiation of the management of anaesthesia for total shoulder replacement (H) (10 basic units)	$1,026.70
21650	Initiation of the management of anaesthesia for procedures on arteries of shoulder or axilla, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30

Item No.	Description	Max Fee (excl. GST)
21652	Initiation of the management of anaesthesia for procedures for axillary brachial aneurysm (H) (10 basic units)	$1,026.70
21654	Initiation of the management of anaesthesia for bypass graft of arteries of shoulder or axilla (H) (8 basic units)	$821.30
21656	Initiation of the management of anaesthesia for axillary femoral bypass graft (H) (10 basic units)	$1,026.70
21670	Initiation of the management of anaesthesia for procedures on veins of shoulder or axilla (H) (4 basic units)	$410.70
21680	Initiation of the management of anaesthesia for shoulder cast application, removal or repair, other than a service to which another item in this Subgroup applies, when undertaken in a hospital (H) (3 basic units)	$308.00
21682	Initiation of the management of anaesthesia for shoulder spica application, when undertaken in a hospital (H) (4 basic units)	$410.70
21685	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or the axilla (H) (10 basic units)	$1,026.70
	Upper arm and elbow	
21700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units)	$308.00
21710	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
21712	Initiation of the management of anaesthesia for open tenotomy of the upper arm or elbow (H) (5 basic units)	$513.30
21714	Initiation of the management of anaesthesia for tenoplasty of the upper arm or elbow (H) (5 basic units)	$513.30
21716	Initiation of the management of anaesthesia for tenodesis for rupture of long tendon of biceps (H) (5 basic units)	$513.30
21730	Initiation of the management of anaesthesia for closed procedures on the upper arm or elbow, when performed in the operating theatre of a hospital (H) (3 basic units)	$308.00
21732	Initiation of the management of anaesthesia for arthroscopic procedures of elbow joint (H) (4 basic units)	$410.70
21740	Initiation of the management of anaesthesia for open procedures on the upper arm or elbow, other than a service to which another item in this Subgroup applies (H) (5 basic units)	$513.30
21756	Initiation of the management of anaesthesia for radical procedures on the upper arm or elbow (H) (6 basic units)	$616.00
21760	Initiation of the management of anaesthesia for total elbow replacement (H) (7 basic units)	$718.70
21770	Initiation of the management of anaesthesia for procedures on arteries of upper arm, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30
21772	Initiation of the management of anaesthesia for embolectomy of arteries of the upper arm (H) (6 basic units)	$616.00
21780	Initiation of the management of anaesthesia for procedures on veins of upper arm, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
21785	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow (H) (10 basic units)	$1,026.70
21790	Initiation of the management of anaesthesia for microsurgical reimplantation of upper arm (H) (15 basic units)	$1,539.90
	Forearm wrist and hand	
21800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units)	$308.00
21810	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (H) (4 basic units)	$410.70
21820	Initiation of the management of anaesthesia for closed procedures on the radius, ulna, wrist, or hand bones, when performed in the operating theatre of a hospital (H) (3 basic units)	$308.00
21830	Initiation of the management of anaesthesia for open procedures on the radius, ulna, wrist, or hand bones, other than a service to which another item in this Subgroup applies (4 basic units)	$410.70
21832	Initiation of the management of anaesthesia for total wrist replacement (H) (7 basic units)	$718.70
21834	Initiation of the management of anaesthesia for arthroscopic procedures of the wrist joint (H) (4 basic units)	$410.70
21840	Initiation of the management of anaesthesia for procedures on the arteries of forearm, wrist or hand, other than a service to which another item in this Subgroup applies (H) (8 basic units)	$821.30
21842	Initiation of the management of anaesthesia for embolectomy of artery of forearm, wrist or hand (H) (6 basic units)	$616.00
21850	Initiation of the management of anaesthesia for procedures on the veins of forearm, wrist or hand, other than a service to which another item in this Subgroup applies (H) (4 basic units)	$410.70
21860	Initiation of the management of anaesthesia for forearm, wrist, or hand cast application, removal or repair, when undertaken in a hospital (H) (3 basic units)	$308.00

Item No.	Description	Max Fee (excl. GST)
21865	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand (H) (10 basic units)	$1,026.70
21870	Initiation of the management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand (H) (15 basic units)	$1,539.90
21872	Initiation of the management of anaesthesia for microsurgical reimplantation of a finger (H) (8 basic units)	$821.30
	Anaesthesia for burns	
21878	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves not more than 3% of total body surface (H) (3 basic units)	$308.00
21879	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves more than 3% but less than 10% of total body surface (H) (5 basic units)	$513.30
21880	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 10% or more but less than 20% of total body surface (H) (7 basic units)	$718.70
21881	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 20% or more but less than 30% of total body surface (H) (9 basic units)	$924.00
21882	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 30% or more but less than 40% of total body surface (H) (11 basic units)	$1,129.20
21883	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 40% or more but less than 50% of total body surface (H) (13 basic units)	$1,334.50
21884	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 50% or more but less than 60% of total body surface (H) (15 basic units)	$1,539.90
21885	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 60% or more but less than 70% of total body surface (H) (17 basic units)	$1,745.20
21886	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 70% or more but less than 80% of total body surface (H) (19 basic units)	$1,950.50
21887	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 80% or more of total body surface (H) (21 basic units)	$2,155.90
	Anaesthesia for radiological or other diagnostic or therapeutic procedures	
21900	Initiation of the management of anaesthesia for injection procedure for hysterosalpingography (H) (3 basic units)	$308.00
21906	Initiation of the management of anaesthesia for injection procedure for myelography lumbar or thoracic (H) (5 basic units)	$513.30
21908	Initiation of the management of anaesthesia for injection procedure for myelography cervical (H) (6 basic units)	$616.00
21910	Initiation of the management of anaesthesia for injection procedure for myelography posterior fossa (H) (9 basic units)	$924.00
21912	Initiation of the management of anaesthesia for injection procedure for discography lumbar or thoracic (H) (5 basic units)	$513.30
21914	Initiation of the management of anaesthesia for injection procedure for discography cervical (H) (6 basic units)	$616.00
21915	Initiation of the management of anaesthesia for peripheral arteriogram (H) (5 basic units)	$513.30
21916	Initiation of the management of anaesthesia for arteriograms cerebral, carotid or vertebral (H) (5 basic units)	$513.30
21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units)	$513.30
21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units)	$616.00
21925	Initiation of the management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography (H) (4 basic units)	$410.70
21926	Initiation of the management of anaesthesia for fluoroscopy (H) (4 basic units)	$410.70
21930	Initiation of the management of anaesthesia for bronchography (H) (6 basic units)	$616.00
21935	Initiation of the management of anaesthesia for phlebography (H) (5 basic units)	$513.30
21936	Initiation of the management of anaesthesia for heart 2 dimensional real time transoesophageal examination (H) (5 basic units)	$513.30
21939	Initiation of the management of anaesthesia for peripheral venous cannulation (H) (3 basic units)	$308.00

Item No.	Description	Max Fee (excl. GST)
21941	Initiation of the management of anaesthesia for cardiac catheterisation (including coronary arteriography, ventriculography, cardiac mappingor insertion of automatic defibrillator or transvenous pacemaker) (H) (7 basic units)	$718.70
21942	Initiation of the management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation (H) (10 basic units)	$1,026.70
21943	Initiation of the 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 (H) (5 basic units)	$513.30
21945	Initiation of the management of anaesthesia for lumbar puncture, cisternal puncture or epidural injection (H) (5 basic units)	$513.30
21949	Initiation of the management of anaesthesia for harvesting of bone marrow for the purpose of transplantation (H) (5 basic units)	$513.30
21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (H) (4 basic units)	$554.90
21955	Initiation of the management of anaesthesia for electroencephalography (H) (5 basic units)	$513.30
21959	Initiation of the management of anaesthesia for brain stem evoked response audiometry (H) (5 basic units)	$513.30
21962	Initiation of the management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method (H) (5 basic units)	$513.30
21965	Initiation of the management of anaesthesia as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (H) (5 basic units)	$513.30
21969	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units)	$821.30
21970	Initiation of the management of anaesthesia during hyperbaric therapy, if the medical practitioner is confined in the chamber (including the administration of oxygen) (H) (15 basic units)	$1,539.90
21973	Initiation of the management of anaesthesia for brachytherapy using radioactive sealed sources (H) (5 basic units)	$513.30
21976	Initiation of the management of anaesthesia for therapeutic nuclear medicine (H) (5 basic units)	$513.30
21980	Initiation of the management of anaesthesia for radiotherapy (H) (5 basic units)	$513.30
	Miscellaneous	
21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)	$308.00
21992	Initiation of the management of anaesthesia performed on a patient under the age of 10 years in connection with a procedure covered by an item that does not include the word (Anaes.) (H) (4 basic units)	$410.70
21997	Initiation of Management of Anaesthesia in connection with a procedure covered by an item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia (4 basic units)	$410.70
	Therapeutic and diagnostic services	
22002	Administration of blood or bone marrow, when performed in association with the management of anaesthesia (H) (4 basic units)	$410.70
22007	Endotracheal intubation with flexible fibreoptic scope associated with difficult airway, when performed in association with the management of anaesthesia (H) (4 basic units)	$410.70
22008	Double lumen endobronchial tube or bronchial blocker, insertion of, when performed in association with the management of anaesthesia (H) (4 basic units)	$410.70
22012	Monitoring that: (a) is of one of the following types of blood pressure: (i) central venous blood pressure; (ii) pulmonary arterial blood pressure; (iii) systemic arterial blood pressure; (iv) cardiac intracavity blood pressure; and (b) is conducted by indwelling catheter; and (c) is performed in association with the administration of anaesthesia for a procedure and not as a service to which item 13876 applies; and (d) is performed, on a day, on a patient who: (i) is categorised as having a high risk of complications; or (ii) during the procedure develops either complications or a high risk of complications; and (e) has not previously been performed in those circumstances on the day on the patient for that type of blood pressure (H) (3 basic units)	$308.00
22014	Monitoring that: (a) is of one of the following types of blood pressure: (i) central venous blood pressure; (ii) pulmonary arterial blood pressure; (iii) systemic arterial blood pressure; (iv) cardiac intracavity blood pressure; and (b) is conducted by indwelling catheter; and (c) is performed in association with the administration of anaesthesia for a procedure (the current procedure) and not as a service to which item 13876 applies; and (d) is performed, on a day, on a patient: (i) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications; and (ii) for whom monitoring of that type of blood pressure to which item 22012 applies has already been performed on the day in association with the administration of anaesthesia for another discrete procedure; and (e) has not previously been performed in association with the current procedure for that type of blood pressure (H) (3 basic units)	$308.00

Item No.	Description	Max Fee (excl. GST)
22015	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the management of anaesthesia (H) (6 basic units)	$616.00
22020	Central vein catheterisation by percutaneous or open exposure, other than a service to which item 13318 applies, when performed in association with the management of anaesthesia (H) (4 basic units)	$410.70
22025	Intra arterial cannulation when performed in association with the management of anaesthesia for a procedure for a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure (H) (4 basic units)	$410.70
22031	Intrathecal or epidural injection (initial) of a therapeutic substance, with or without insertion of a catheter, in association with anaesthesia and surgery, for post operative pain management, other than a service associated with a service to which item 22036 applies (H) (5 basic units)	$513.30
22032	Introduction of a plexus or nerve block to a peripheral nerve, perioperatively performed using an in situ catheter in association with anaesthesia and surgery, for post operative pain management (H) (4 basic units)	$391.50
22036	Intrathecal or epidural injection (subsequent) of a therapeutic substance, using an in situ catheter, in association with anaesthesia and surgery, for post operative pain, other than a service associated with a service to which item 22031 applies (H) (3 basic units)	$308.00
22041	Introduction of a plexus or nerve block proximal to the lower leg or forearm, perioperatively performed in the induction room, theatre or recovery room, for post operative pain management (H) (2 basic units)	$205.30
22042	Introduction of a nerve block performed via a retrobulbar, peribulbar, or sub Tenon s approach, or other complex eye block, when administered by an anaesthetist perioperatively (1 basic units)	$102.70
22051	Intra operative transoesophageal echocardiography monitoring in real time 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, other than a service associated with a service to which item 55130, 55135 or 21936 applies (H) (9 basic units)	$924.00
22052	Transfusion of blood by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 13703 applies (H) (6 basic units)	$616.00
22053	Insertion of lumbar cerebrospinal fluid drain, by an anaesthetist at the request of the treating specialist, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 40018 applies (H) (6 basic units)	$616.00
22054	Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography by an anaesthetist, where the service: (a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and (b) includes Doppler techniques with colour flow mapping and recordings on digital media; and (c) is performed during cardiac valve surgery (replacement or repair); and (d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and (e) is not associated with a service to which item 21936, 22051, 55118, 55130 or 55135 applies; and (f) is provided on the same occasion as the administration of anaesthesia by the same anaesthetist (H) (18 basic units)	$1,847.90
22055	Perfusion of limb or organ using heart lung machine or equivalent, other than a service associated with anaesthesia to which an item in Subgroup 21 applies (H) (12 basic units)	$1,231.90
22060	Whole body perfusion, cardiac bypass, if the heart lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies (H) (30 basic units)	$3,079.90
22065	Induced controlled hypothermia total body, that is: (a) a service to which item 22060 applies; and (b) not a service associated with anaesthesia, to which an item in Subgroup 21 applies (H) (5 basic units)	$513.30
22075	Deep hypothermic circulatory arrest, with core temperature less than 22 c, including management of retrograde cerebral perfusion (if performed), other than a service associated with anaesthesia to which an item in Subgroup 21 applies (H) (15 basic units)	$1,539.90
	Administration of anaesthesia in connection with a dental service	
22900	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)	$616.00
22905	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)	$616.00
	Anaesthesia/perfusion time units	
23010	Anaesthesia, perfusion or assistance, if the service time is not more than 15 minutes (1 basic units)	$102.70
23025	16 minutes to 30 minutes (2 basic units)	$205.30
23035	31 minutes to 45 minutes (3 basic units)	$308.00
23045	46 minutes to 1:00 HOUR (4 basic units)	$410.70
23055	1:01 HOURS to 1:15 HOURS (5 basic units)	$513.30
23065	1:16 HOURS to 1:30 HOURS (6 basic units)	$616.00

Item No.	Description	Max Fee (excl. GST)
23075	1:31 HOURS to 1:45 HOURS (7 basic units)	$718.70
23085	1:46 HOURS to 2:00 HOURS (8 basic units)	$821.30
23091	2:01 HOURS TO 2:10 HOURS (9 basic units)	$924.00
23101	2:11 HOURS TO 2:20 HOURS (10 basic units)	$1,026.70
23111	2:21 HOURS TO 2:30 HOURS (11 basic units)	$1,129.20
23112	2:31 HOURS TO 2:40 HOURS (12 basic units)	$1,231.90
23113	2:41 HOURS TO 2:50 HOURS (13 basic units)	$1,334.50
23114	2:51 HOURS TO 3:00 HOURS (14 basic units)	$1,437.20
23115	3:01 HOURS TO 3:10 HOURS (15 basic units)	$1,539.90
23116	3:11 HOURS TO 3:20 HOURS (16 basic units)	$1,642.50
23117	3:21 HOURS TO 3:30 HOURS (17 basic units)	$1,745.20
23118	3:31 HOURS TO 3:40 HOURS (18 basic units)	$1,847.90
23119	3:41 HOURS TO 3:50 HOURS (19 basic units)	$1,950.50
23121	3:51 HOURS TO 4:00 HOURS (20 basic units)	$2,053.20
23170	4:01 HOURS TO 4:10 HOURS (21 basic units)	$2,155.90
23180	4:11 HOURS TO 4:20 HOURS (22 basic units)	$2,258.50
23190	4:21 HOURS TO 4:30 HOURS (23 basic units)	$2,361.20
23200	4:31 HOURS TO 4:40 HOURS (24 basic units)	$2,463.90
23210	4:41 HOURS TO 4:50 HOURS (25 basic units)	$2,566.50
23220	4:51 HOURS TO 5:00 HOURS (26 basic units)	$2,669.20
23230	5:01 HOURS TO 5:10 HOURS (27 basic units)	$2,771.90
23240	5:11 HOURS TO 5:20 HOURS (28 basic units)	$2,874.50
23250	5:21 HOURS TO 5:30 HOURS (29 basic units)	$2,977.20
23260	5:31 HOURS TO 5:40 HOURS (30 basic units)	$3,079.90
23270	5:41 HOURS TO 5:50 HOURS (31 basic units)	$3,182.50
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units)	$3,285.20
23290	6:01 HOURS TO 6:10 HOURS (33 basic units)	$3,387.70
23300	6:11 HOURS TO 6:20 HOURS (34 basic units)	$3,490.40
23310	6:21 HOURS TO 6:30 HOURS (35 basic units)	$3,593.10
23320	6:31 HOURS TO 6:40 HOURS (36 basic units)	$3,695.70
23330	6:41 HOURS TO 6:50 HOURS (37 basic units)	$3,798.40
23340	6:51 HOURS TO 7:00 HOURS (38 basic units)	$3,901.10
23350	7:01 HOURS TO 7:10 HOURS (39 basic units)	$4,003.70
23360	7:11 HOURS TO 7:20 HOURS (40 basic units)	$4,106.40
23370	7:21 HOURS TO 7:30 HOURS (41 basic units)	$4,209.10
23380	7:31 HOURS TO 7:40 HOURS (42 basic units)	$4,311.70
23390	7:41 HOURS TO 7:50 HOURS (43 basic units)	$4,414.40
23400	7:51 HOURS TO 8:00 HOURS (44 basic units)	$4,517.10
23410	8:01 HOURS TO 8:10 HOURS (45 basic units)	$4,619.70
23420	8:11 HOURS TO 8:20 HOURS (46 basic units)	$4,722.40
23430	8:21 HOURS TO 8:30 HOURS (47 basic units)	$4,825.10
23440	8:31 HOURS TO 8:40 HOURS (48 basic units)	$4,927.70
23450	8:41 HOURS TO 8:50 HOURS (49 basic units)	$5,030.40
23460	8:51 HOURS TO 9:00 HOURS (50 basic units)	$5,133.10
23470	9:01 HOURS TO 9:10 HOURS (51 basic units)	$5,235.70
23480	9:11 HOURS TO 9:20 HOURS (52 basic units)	$5,338.40
23490	9:21 HOURS TO 9:30 HOURS (53 basic units)	$5,441.00
23500	9:31 HOURS TO 9:40 HOURS (54 basic units)	$5,543.70
23510	9:41 HOURS TO 9:50 HOURS (55 basic units)	$5,646.30
23520	9:51 HOURS TO 10:00 HOURS (56 basic units)	$5,748.90

Item No.	Description	Max Fee (excl. GST)
23530	10:01 HOURS TO 10:10 HOURS (57 basic units)	$5,851.60
23540	10:11 HOURS TO 10:20 HOURS (58 basic units)	$5,954.30
23550	10:21 HOURS TO 10:30 HOURS (59 basic units)	$6,056.90
23560	10:31 HOURS TO 10:40 HOURS (60 basic units)	$6,159.60
23570	10:41 HOURS TO 10:50 HOURS (61 basic units)	$6,262.30
23580	10:51 HOURS TO 11:00 HOURS (62 basic units)	$6,364.90
23590	11:01 HOURS TO 11:10 HOURS (63 basic units)	$6,467.60
23600	11:11 HOURS TO 11:20 HOURS (64 basic units)	$6,570.30
23610	11:21 HOURS TO 11:30 HOURS (65 basic units)	$6,672.90
23620	11:31 HOURS TO 11:40 HOURS (66 basic units)	$6,775.60
23630	11:41 HOURS TO 11:50 HOURS (67 basic units)	$6,878.30
23640	11:51 HOURS TO 12:00 HOURS (68 basic units)	$6,980.90
23650	12:01 HOURS TO 12:10 HOURS (69 basic units)	$7,083.60
23660	12:11 HOURS TO 12:20 HOURS (70 basic units)	$7,186.30
23670	12:21 HOURS TO 12:30 HOURS (71 basic units)	$7,288.90
23680	12:31 HOURS TO 12:40 HOURS (72 basic units)	$7,391.60
23690	12:41 HOURS TO 12:50 HOURS (73 basic units)	$7,494.20
23700	12:51 HOURS TO 13:00 HOURS (74 basic units)	$7,596.90
23710	13:01 HOURS TO 13:10 HOURS (75 basic units)	$7,699.60
23720	13:11 HOURS TO 13:20 HOURS (76 basic units)	$7,802.10
23730	13:21 HOURS TO 13:30 HOURS (77 basic units)	$7,904.80
23740	13:31 HOURS TO 13:40 HOURS (78 basic units)	$8,007.50
23750	13:41 HOURS TO 13:50 HOURS (79 basic units)	$8,110.10
23760	13:51 HOURS TO 14:00 HOURS (80 basic units)	$8,212.80
23770	14:01 HOURS TO 14:10 HOURS (81 basic units)	$8,315.50
23780	14:11 HOURS TO 14:20 HOURS (82 basic units)	$8,418.10
23790	14:21 HOURS TO 14:30 HOURS (83 basic units)	$8,520.80
23800	14:31 HOURS TO 14:40 HOURS (84 basic units)	$8,623.50
23810	14:41 HOURS TO 14:50 HOURS (85 basic units)	$8,726.10
23820	14:51 HOURS TO 15:00 HOURS (86 basic units)	$8,828.80
23830	15:01 HOURS TO 15:10 HOURS (87 basic units)	$8,931.50
23840	15:11 HOURS TO 15:20 HOURS (88 basic units)	$9,034.10
23850	15:21 HOURS TO 15:30 HOURS (89 basic units)	$9,136.80
23860	15:31 HOURS TO 15:40 HOURS (90 basic units)	$9,239.50
23870	15:41 HOURS TO 15:50 HOURS (91 basic units)	$9,342.10
23880	15:51 HOURS TO 16:00 HOURS (92 basic units)	$9,444.80
23890	16:01 HOURS TO 16:10 HOURS (93 basic units)	$9,547.40
23900	16:11 HOURS TO 16:20 HOURS (94 basic units)	$9,650.10
23910	16:21 HOURS TO 16:30 HOURS (95 basic units)	$9,752.80
23920	16:31 HOURS TO 16:40 HOURS (96 basic units)	$9,855.40
23930	16:41 HOURS TO 16:50 HOURS (97 basic units)	$9,958.10
23940	16:51 HOURS TO 17:00 HOURS (98 basic units)	$10,060.70
23950	17:01 HOURS TO 17:10 HOURS (99 basic units)	$10,163.30
23960	17:11 HOURS TO 17:20 HOURS (100 basic units)	$10,266.00
23970	17:21 HOURS TO 17:30 HOURS (101 basic units)	$10,368.70
23980	17:31 HOURS TO 17:40 HOURS (102 basic units)	$10,471.30
23990	17:41 HOURS TO 17:50 HOURS (103 basic units)	$10,574.00
24100	17:51 HOURS TO 18:00 HOURS (104 basic units)	$10,676.70
24101	18:01 HOURS TO 18:10 HOURS (105 basic units)	$10,779.30
24102	18:11 HOURS TO 18:20 HOURS (106 basic units)	$10,882.00

Item No.	Description	Max Fee (excl. GST)
24103	18:21 HOURS TO 18:30 HOURS (107 basic units)	$10,984.70
24104	18:31 HOURS TO 18:40 HOURS (108 basic units)	$11,087.30
24105	18:41 HOURS TO 18:50 HOURS (109 basic units)	$11,190.00
24106	18:51 HOURS TO 19:00 HOURS (110 basic units)	$11,292.70
24107	19:01 HOURS TO 19:10 HOURS (111 basic units)	$11,395.30
24108	19:11 HOURS TO 19:20 HOURS (112 basic units)	$11,498.00
24109	19:21 HOURS TO 19:30 HOURS (113 basic units)	$11,600.60
24110	19:31 HOURS TO 19:40 HOURS (114 basic units)	$11,703.30
24111	19:41 HOURS TO 19:50 HOURS (115 basic units)	$11,806.00
24112	19:51 HOURS TO 20:00 HOURS (116 basic units)	$11,908.60
24113	20:01 HOURS TO 20:10 HOURS (117 basic units)	$12,011.30
24114	20:11 HOURS TO 20:20 HOURS (118 basic units)	$12,114.00
24115	20:21 HOURS TO 20:30 HOURS (119 basic units)	$12,216.50
24116	20:31 HOURS TO 20:40 HOURS (120 basic units)	$12,319.20
24117	20:41 HOURS TO 20:50 HOURS (121 basic units)	$12,421.90
24118	20:51 HOURS TO 21:00 HOURS (122 basic units)	$12,524.50
24119	21:01 HOURS TO 21:10 HOURS (123 basic units)	$12,627.20
24120	21:11 HOURS TO 21:20 HOURS (124 basic units)	$12,729.90
24121	21:21 HOURS TO 21:30 HOURS (125 basic units)	$12,832.50
24122	21:31 HOURS TO 21:40 HOURS (126 basic units)	$12,935.20
24123	21:41 HOURS TO 21:50 HOURS (127 basic units)	$13,037.90
24124	21:51 HOURS TO 22:00 HOURS (128 basic units)	$13,140.50
24125	22:01 HOURS TO 22:10 HOURS (129 basic units)	$13,243.20
24126	22:11 HOURS TO 22:20 HOURS (130 basic units)	$13,345.90
24127	22:21 HOURS TO 22:30 HOURS (131 basic units)	$13,448.50
24128	22:31 HOURS TO 22:40 HOURS (132 basic units)	$13,551.20
24129	22:41 HOURS TO 22:50 HOURS (133 basic units)	$13,653.80
24130	22:51 HOURS TO 23:00 HOURS (134 basic units)	$13,756.50
24131	23:01 HOURS TO 23:10 HOURS (135 basic units)	$13,859.20
24132	23:11 HOURS TO 23:20 HOURS (136 basic units)	$13,961.80
24133	23:21 HOURS TO 23:30 HOURS (137 basic units)	$14,064.50
24134	23:31 HOURS TO 23:40 HOURS (138 basic units)	$14,167.20
24135	23:41 HOURS TO 23:50 HOURS (139 basic units)	$14,269.80
24136	23:51 HOURS TO 24:00 HOURS (140 basic units)	$14,372.50
	Anaesthesia/perfusion modifying units—physical status	
25000	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient has severe systemic disease (equivalent to ASA physical status indicator 3) (1 basic units)	$102.70
25005	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient has severe systemic disease which is a constant threat to life (equivalent to ASA physical status indicator 4) (H) (2 basic units)	$205.30
25010	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is not expected to survive for 24 hours, with or without the associated operation (equivalent to ASA physical status indicator 5) (H) (3 basic units)	$308.00
	Anaesthesia/perfusion modifying units—other	
25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (1 basic units)	$102.70
25020	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part other than a service associated with a service to which item 25025, 25030 or 25050 applies (H) (2 basic units)	$205.30

Item No.	Description	Max Fee (excl. GST)
	Anaesthesia after hours emergency modifier	
25025	Anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (H) (0 basic units) Derived fee: An additional amount of 50% of fee for the anaesthetic service. That is: (a) an anaesthesia item/s range 20100 - 21997 or 22900, plus (b) an item range 23010 - 24136, plus (c) if applicable,an item range 25000-25014, plus (d) where performed, any assoc therapeutic or diagnostic service range 22002-22051	DF
25030	Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (H) (0 basic units) Derived fee: 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (d) where performed, any associated therapeutic or diagnostic service 22002 -22051	DF
	Perfusion after hours emergency modifier	
25050	Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (H) (0 basic units) Derived fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item range 23010 - 24136, plus (c) where applicable, an item range 25000 - 25014, plus (d) where performed, any associated therapeutic or diagnostic service in the range 22002-22051 or 22065-22075	DF
	Assistance at anaesthesia	
25200	Assistance in the management of anaesthesia requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of attendance on all other patients (H) (5 basic units) Derived fee: An amount of $489.30 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable, an item in the range 25000 - 25020, plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051	DF
25205	Assistance in the management of elective anaesthesia, if: (a)the patient has complex airway problems; or (b) the patient is a neonate; or (c) the patient is a paediatric patient and is receiving one or more of the following services: (i) invasive monitoring, either intravascular or transoesophageal; (ii) organ transplantation; (iii) craniofacial surgery; (iv) major tumour resection; (v) separation of conjoint twins; or (d) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (e) the patient is critically ill, with multiple organ failure; or (f) the service time of the management of anaesthesia exceeds 6 hours and the assistance is provided to the exclusion of attendance on all other patients (H) (5 basic units) Derived fee: An amount of $489.30 (5 basic units), plus an item in the range 23010 - 24136, plus, where applicable, an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051	DF
GROUP T8—SURGICAL OPERATIONS		
	General	
30001	Operative procedure, not being a service to which any other item i n this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds Derived fee : 50% of the fee which would have applied had the procedure not been discontinued.	DF
30003	Burns, involving 1% or more but less than 3% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present each attendance at which the procedure is performedNot applicable for skin reactions secondary to radiotherapy	$80.50
30006	Burns, involving 3% or more but less than 10% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present each attendance at which the procedure is performedNot applicable for skin reactions secondary to radiotherapy	$109.10
30007	Burns, involving 10% or more of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present each attendance at which the procedure is performedNot applicable for skin reactions secondary to radiotherapy	$323.60
30010	Burns, involving not more than 3% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.)	$176.00
30014	Burns, involving 3% or more but less than 20% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.)	$369.40
30015	Burns, involving 20% or more but less than 50% of total body surface, or burns of less than 20% of total body surface involving 1% or more of total body surface within the hands or face, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.)	$485.40

Item No.	Description	Max Fee (excl. GST)
30016	Burns, involving 50% or more of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.)	$727.90
30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)	$781.30
30024	Wound of soft tissue, debridement of an extensively infected post surgical incision or Fournier s gangrene, under general anaesthesia, or regional or field nerve block, including suturing of the wound if carried out (H) (Anaes.) (Assist.)	$777.50
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.)	$122.30
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 LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$210.70
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.)	$192.90
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7cm LONG), involving deeper tissue (Anaes.)	$275.50
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.)	$210.70
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, other than a service to which another item in Group T4 applies (Anaes.)	$444.80
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.)	$275.50
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.)	$440.60
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	$599.60
30055	Wounds, dressing of, under general, regional or intravenous sedation, with or without removal of sutures, other than a service associated with a service to which another item in this Group applies (Anaes.)	$176.00
30058	Post operative haemorrhage, control of, under general anaesthesia, as an independent procedure (H) (Anaes.)	$322.80
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)	$52.70
30062	Etonogestrel subcutaneous implant, removal of (Anaes.)	$141.70
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	$257.40
30068	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)	$657.80
30071	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	$124.40
30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	$118.30
30075	DIAGNOSTIC BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	$334.40
30078	DIAGNOSTIC DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	$116.10
30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)	$258.50
30084	Diagnostic biopsy of bone marrow by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.)	$139.80
30087	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.)	$70.30

Item No.	Description	Max Fee (excl. GST)
30090	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.)	$305.60
30093	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.)	$398.90
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.)	$449.80
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if: serum cortisol at 0830-0930 hours on any day in the preceding month has been measured at greater than 100 nmol/L but less than 400 nmol/L; or in a patient who is acutely unwell and adrenal insufficiency is suspected.	$231.00
30099	Sinus, excision of, involving superficial tissue only (Anaes.)	$200.90
30103	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$436.10
30104	Pre-auricular sinus, excision of, on a patient 10 years of age or over (Anaes.)	$303.70
30107	Excision of ganglion, other than a service associated with a service to which another item in this Group applies (Anaes.)	$490.80
30166	Removal of redundant abdominal skin and lipectomy, as a wedge excision, for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, other than a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.)	$1,561.80
30169	Removal of redundant non-abdominal skin and lipectomy for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, one or 2 non-abdominal areas, other than a service associated with a service to which item 30175, 30176, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.)	$1,249.40
30176	Radical abdominoplasty, with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30169, 30175, 30177, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (H) (Anaes.) (Assist.)	$2,278.30
30177	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty, with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30175, 30176, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	$2,192.40
30179	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty, not being a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies, if: (a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	$2,803.80
30180	Axillary hyperhidrosis, partial excision for (Anaes.)	$323.10
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (H) (Anaes.)	$585.60
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.)	$555.60
30189	Warts or molluscum contagiosum (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this group applies (H) (Anaes.)	$334.10
30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.)	$945.00

Item No.	Description	Max Fee (excl. GST)
30191	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions.	$138.50
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)	$93.40
30196	Malignant neoplasm of skin or mucous membrane that has been: (a) proven by histopathology; or (b) confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery where a specimen has been submitted for histologic confirmation; removal of, by serial curettage, or carbon dioxide laser or erbium laser excision ablation, including any associated cryotherapy or diathermy (Anaes.)	$294.30
30202	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles	$112.60
30207	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)	$106.10
30210	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital (H) (Anaes.)	$387.20
30216	Haematoma, aspiration of (Anaes.)	$62.20
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)	$62.20
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)	$387.60
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.)	$568.70
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.)	$635.40
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)	$356.00
30229	Muscle, excision of (extensive) (H) (Anaes.) (Assist.)	$650.00
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.)	$531.50
30235	Muscle, ruptured, repair of (extensive), not associated with external wound (H) (Anaes.) (Assist.)	$704.30
30238	Fascia, deep, repair of, for herniated muscle (Anaes.)	$355.90
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$795.70
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	$842.50
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.)	$1,642.80
30247	Parotid gland, total extirpation of, including removal of tumour, other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	$1,765.70
30250	Parotid gland, total extirpation of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	$2,956.80
30251	Recurrent parotid tumour, excision of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	$4,570.80
30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	$1,872.00
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)	$2,617.30
30256	Submandibular gland, extirpation of, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.)	$995.80
30257	Sialendoscopy, of submandibular or parotid duct, with or without removal of calculus or treatment of stricture (Anaes.)	$1,004.80
30259	Sublingual gland, extirpation of (H) (Anaes.)	$476.00
30262	Salivary gland, dilatation or diathermy of duct (Anaes.)	$140.30
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.)	$334.30

Item No.	Description	Max Fee (excl. GST)
30269	Salivary gland, repair of cutaneous fistula of (H) (Anaes.)	$361.90
30272	Tongue, partial excision of (H) (Anaes.) (Assist.)	$660.80
30275	Radical excision of intra oral tumour, with or without resection of mandible, including dissection of lymph glands of neck, unilateral, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.)	$3,936.90
30278	Tongue tie, repair of, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 45009 applies (Anaes.)	$109.90
30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a patient at least 2 years old, other than a service associated with a service to which item 45009 applies (Anaes.)	$278.00
30283	Ranula or mucous cyst of mouth, removal of (Anaes.)	$457.70
30286	Branchial cyst, removal of, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	$893.50
30289	Branchial fistula, removal of, on a patient 10 years of age or over (Anaes.) (Assist.)	$1,164.70
30293	Cervical oesophagostomy, or closure of cervical oesophagostomy with or without plastic repair (H) (Anaes.) (Assist.)	$1,059.10
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.)	$4,106.50
30296	THYROIDECTOMY, total (Anaes.) (Assist.)	$2,425.30
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.)	$2,285.90
30299	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in an axilla, using preoperative lymphoscintigraphy and/or lymphotropic dye injection (H) (Anaes.) (Assist.)	$1,667.00
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)	$1,815.30
30310	Partial or subtotal thyroidectomy (Anaes.) (Assist.)	$1,276.80
30311	Sentinel lymph node biopsy or biopsies for cutaneous melanoma, using preoperative lymphoscintigraphy and/or lymphotropic dye injection, if: (a) the primary lesion is greater than 1.0mm in depth (or at least 0.8mm in depth in the presence of ulceration); and (b) appropriate excision of the primary melanoma has occurred; and (c) the service is not associated with a service to which item 30075, 30078, 30299, 30305, 30329, 30332, 30618, 30820, 31423, 52025 or 52027 appliesApplicable to only one lesion per occasion on which the service is provided (H) (Anaes.) (Assist.)	$1,375.70
30314	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient 10 years of age or over (Anaes.) (Assist.)	$1,106.20
30315	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma through a small cervical incision for an image localised adenoma, including thymectomy. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30318, 30317 or 30320 applies. (Anaes.) (Assist.)	$2,547.00
30317	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperparathyroidism, including thymectomy and cervical exploration of the mediastinum. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30318 or 30320 applies. (Anaes.) (Assist.)	$3,243.70
30318	Open parathyroidectomy, exploration and removal of 1 or more adenoma or hyperplastic glands via a cervical incision including thymectomy and cervical exploration of the mediastinum when performed. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30317 or 30320 applies. (Anaes.) (Assist.)	$2,525.60
30320	Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thorascopic approach. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30317 or 30318 applies. (Anaes.) (Assist.)	$3,243.70
30323	Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.)	$3,243.70
30324	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.)	$3,251.10
30329	LYMPH NODES of GROIN, limited excision of (Anaes.)	$556.40
30330	LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.)	$1,710.00
30332	Lymph nodes of axilla, limited excision of (H) (Anaes.) (Assist.)	$781.00
30336	Lymph nodes of axilla, complete excision of (H) (Anaes.) (Assist.)	$2,326.90
30382	Enterocutaneous fistula, repair of, if dissection and resection of bowel is performed, with or without anastomosis or formation of a stoma (H) (Anaes.) (Assist.)	$3,107.30

Item No.	Description	Max Fee (excl. GST)
30384	Open or minimally invasive excision of a retroperitoneal mass, 4cm or greater in largest dimension, lasting more than 3 hours, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$2,980.50
30385	Unplanned return to theatre for laparotomy or laparoscopy for control or drainage of intra-abdominal haemorrhage following abdominal surgery (H) (Anaes.) (Assist.)	$1,339.70
30387	Laparoscopy or laparotomy when an operation is performed on abdominal, retroperitoneal or pelvic viscera, excluding lymph node biopsy, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,469.00
30388	Laparotomy for abdominal trauma, including control of haemorrhage (with or without packing) and containment of contamination (H) (Anaes.) (Assist.)	$3,215.30
30390	Laparoscopy, diagnostic, with or without aspiration of fluid, on a patient 10 years of age or over, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.)	$523.60
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.)	$1,604.90
30396	Laparotomy or laparoscopy for generalised intra-peritoneal sepsis (also known as peritonitis), with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity, with or without closure of the abdomen when performed by laparotomy (H) (Anaes.) (Assist.)	$2,418.40
30397	Laparostomy, via wound previously made and left open or closed, including change of dressings or packs, with or without drainage of loculated collections (H) (Anaes.)	$552.60
30399	Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs (Anaes.) (Assist.)	$758.20
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.)	$1,505.20
30406	Paracentesis abdominis (Anaes.)	$124.00
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.)	$931.90
30409	Liver biopsy, percutaneous (Anaes.)	$417.60
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.)	$209.80
30412	Liver biopsy by core needle, when performed in conjunction with another intra abdominal procedure (H) (Anaes.)	$124.30
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.)	$1,641.30
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.)	$3,271.70
30416	Liver cysts, greater than 5cm in diameter, marsupialisation of 4 or less (Anaes.) (Assist.)	$1,778.00
30417	Liver cysts, greater than 5cm in diameter, marsupialisation of 5 or more (Anaes.) (Assist.)	$2,666.60
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.)	$3,796.40
30419	Liver tumour, other than a hepatocellular carcinoma, destruction of one or more, by local ablation, other than a service associated with a service to which item 50950 or 50952 applies (H) (Anaes.) (Assist.)	$1,841.00
30421	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, other than for trauma (Anaes.) (Assist.)	$4,739.30
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.)	$1,602.10
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)	$3,107.30
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.)	$3,655.00
30428	Liver, lobectomy of, for trauma (H) (Anaes.) (Assist.)	$3,910.50
30430	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, for trauma (H) (Anaes.) (Assist.)	$5,516.20
30431	Liver abscess, single, open or minimally invasive abdominal drainage of, excluding aftercare (H) (Anaes.) (Assist.)	$1,236.90
30433	Liver abscess, multiple, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.)	$1,635.10
30439	Intraoperative ultrasound of biliary tract, or operative cholangiography, if the service: (a) is performed in association with an intra-abdominal procedure; and (b) is not associated with a service to which item 30442 or 30445 applies (Anaes.) (Assist.)	$441.70
30440	Cholangiogram, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques, other than a service associated with a service to which item 30451 applies (H) (Anaes.) (Assist.)	$1,252.80
30441	Intraoperative ultrasound for staging of intra-abdominal tumours (Anaes.)	$323.80

Item No.	Description	Max Fee (excl. GST)
30442	Choledochoscopy in conjunction with another procedure (Anaes.)	$444.80
30443	Cholecystectomy, by any approach, without cholangiogram (Anaes.) (Assist.)	$1,488.30
30445	Cholecystectomy, by any approach, with attempted or completed cholangiogram or intraoperative ultrasound of the biliary system, when performed via laparoscopic or open approach or when conversion from laparoscopic to open approach is required (Anaes.) (Assist.)	$1,844.60
30448	Cholecystectomy, by any approach, involving removal of common duct calculi via the cystic duct, with or without stent insertion (Anaes.) (Assist.)	$2,311.80
30449	Cholecystectomy with removal of common duct calculi via choledochotomy, by any approach, with or without insertion of a stent (Anaes.) (Assist.)	$2,573.20
30450	Calculus of biliary tract, extraction of, using interventional imaging techniques (H) (Anaes.) (Assist.)	$1,245.50
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.)	$635.60
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.)	$843.40
30454	Choledochotomy without cholecystectomy, with or without removal of calculi (Anaes.) (Assist.)	$2,368.30
30455	Choledochotomy with cholecystectomy, with removal of calculi, including biliary intestinal anastomosis (Anaes.) (Assist.)	$2,750.80
30457	Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (H) (Anaes.) (Assist.)	$3,283.00
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.)	$2,414.90
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.)	$2,048.60
30461	Radical resection of porta hepatis (including associated neuro-lymphatic tissue), for cancer, suspected cancer or choledochal cyst, including bile duct excision and biliary-enteric anastomoses, other than a service associated with a service to which item 30440, 30451 or 31454 applies (Anaes.) (Assist.)	$3,301.80
30463	Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses, for cancer, suspected cancer or choledochal cyst (Anaes.) (Assist.)	$4,195.40
30464	Radical resection of common hepatic duct and right and left hepatic ducts, for cancer, suspected cancer or choledochal cyst, involving either or both of the following: (a) more than 2 anastomoses; (b) resection of segment (or major portion of segment) of liver; (Anaes.) (Assist.)	$5,176.60
30469	Biliary stricture, repair of, after one or more operations on the biliary tree (H) (Anaes.) (Assist.)	$4,087.60
30472	Repair of bile duct injury, including immediate reconstruction, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.)	$2,537.00
30473	Oesophagoscopy (not being a service associated with a service to which item 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30478 or 30479 applies. (Anaes.)	$420.40
30475	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification if clinically indicated) (H) (Anaes.)	$829.90
30478	Oesophagoscopy (other than a service associated with a service to which item 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if: (a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (H) (Anaes.)	$585.40
30479	Endoscopy with laser therapy, for the treatment of one or more of the following: (a) neoplasia; (b) benign vascular lesions; (c) strictures of the gastrointestinal tract; (d) tumorous overgrowth through or over oesophageal stents; (e) peptic ulcers; (f) angiodysplasia; (g) gastric antral vascular ectasia; (h) post-polypectomy bleeding; other than a service associated with a service to which item 30473 or 30478 applies (Anaes.)	$1,132.10
30481	Percutaneous gastrostomy (initial procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (H) (Anaes.)	$797.70
30482	Percutaneous Gastrostomy (repeat procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	$572.00

Item No.	Description	Max Fee (excl. GST)
30483	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device: (a) non-endoscopic insertion of; or (b) non-endoscopic replacement of; on a patient 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	$395.30
30484	Endoscopic retrograde cholangiopancreatography, other than a service to which item 30664 or 30665 applies (H) (Anaes.)	$822.30
30485	Endoscopic sphincterotomy with or without extraction of stones from common bile duct (H) (Anaes.)	$1,339.70
30488	Small bowel intubation as an independent procedure (H) (Anaes.)	$201.00
30490	Oesophageal prosthesis, insertion of, including endoscopy and dilatation (H) (Anaes.)	$1,175.50
30491	Bile duct, endoscopic stenting of (including endoscopy and dilatation) (H) (Anaes.)	$1,239.00
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.)	$1,756.80
30494	Endoscopic biliary dilatation (Anaes.)	$1,000.90
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.)	$1,756.80
30515	Gastroenterostomy (including gastroduodenostomy), enterocolostomy or enteroenterostomy, as an independent procedure or in combination with another procedure, only if required for irresectable obstruction, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.)	$1,677.70
30517	Revision of gastroenterostomy, pyloroplasty or gastroduodenostomy (Anaes.) (Assist.)	$2,205.10
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.)	$2,349.80
30520	Gastric tumour, 2cm or greater in diameter, removal of, by local excision, by laparoscopic or open approach, including any associated anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.)	$1,831.70
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.)	$3,371.70
30526	Gastrectomy, total, and removal of lower oesophagus, performed by open or minimally invasive approach, with anastomosis in the mediastinum, including any of the following (if performed): (a) distal pancreatectomy; (b) nodal dissection; (c) splenectomy (Anaes.) (Assist.)	$5,116.60
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.)	$3,107.30
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.)	$1,860.60
30532	Oesophagogastric myotomy (Heller s operation) by endoscopic, abdominal or thoracic approach, whether performed by open or minimally invasive approach, including fundoplication when performed laparoscopically (Anaes.) (Assist.)	$2,138.80
30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.)	$2,543.80
30559	Oesophagus, local excision for tumour of (H) (Anaes.) (Assist.)	$2,020.30
30560	Oesophageal perforation, repair of, by abdominal or thoracic approach, including thoracic drainage (Anaes.) (Assist.)	$2,242.60
30562	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient 10 years of age or over (Anaes.) (Assist.)	$1,417.20
30563	Colostomy or ileostomy, refashioning of, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	$1,417.20
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.)	$2,069.30
30574	NOTE: Multiple Operation and Multiple Anaesthetic rules apply to this item Appendicectomy, when performed in conjunction with another intra-abdominal procedure and during which a specimen is collected and sent for pathological testing (Anaes.)	$197.20
30577	Initial pancreatic necrosectomy by open, laparoscopic or endoscopic approach, excluding aftercare (Anaes.) (Assist.)	$2,582.30
30583	Distal pancreatectomy with splenic preservation, by open or minimally invasive approach (Anaes.) (Assist.)	$3,281.80
30584	Pancreatico duodenectomy (Whipple s procedure), with or without preservation of pylorus, including any of the following (if performed): (a) cholecystectomy; (b) pancreatico-biliary anastomosis; (c) gastro-jejunal anastomosis (Anaes.) (Assist.)	$4,795.10
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)	$2,970.90
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)	$3,271.70

Item No.	Description	Max Fee (excl. GST)
30593	Pancreatectomy, near total or total (including duodenum), with or without splenectomy (H) (Anaes.) (Assist.)	$4,485.30
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.)	$5,176.60
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)	$2,136.30
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.)	$3,107.30
30600	Emergency repair of diaphragmatic laceration or hernia, following recent trauma, by any approach, including when performed in conjunction with another procedure indicated as a result of abdominal or chest trauma (Anaes.) (Assist.)	$1,849.00
30601	Diaphragmatic hernia, congenital, or delayed presentation of traumatic rupture, repair of, by thoracic or abdominal approach, on a patient 10 years of age or over, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.)	$2,280.20
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.)	$2,640.30
30615	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a patient 10 years of age or over (Anaes.) (Assist.)	$1,236.90
30621	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other repair, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30651, 30655, 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764 applies (H) (Anaes.) (Assist.)	$968.80
30628	Hydrocele, tapping of	$80.70
30629	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.)	$1,141.70
30630	Insertion of testicular prosthesis, at least 6 months following orchidectomy (H) (Anaes.) (Assist.)	$518.90
30631	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (H) (Anaes.)	$534.70
30635	Varicocele, surgical correction of, including microsurgical techniques, other than a service associated with a service to which item 30390, 30627, 30641, 30642 or 30644 applies one procedure (Anaes.) (Assist.)	$698.30
30640	Repair of large and irreducible scrotal hernia, if surgery exceeds 2 hours, in a patient 10 years of age or over, other than a service to which item 30615, 30621, 30648, 30651 or 30655 applies (Anaes.) (Assist.)	$2,071.30
30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (H) (Anaes.) (Assist.)	$909.10
30642	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies (Anaes.) (Assist.)	$1,161.20
30643	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient under 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)	$1,565.90
30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient at least 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)	$1,174.80
30648	Femoral or inguinal hernia or infantile hydrocele, repair of, by open or minimally invasive approach, on a patient 10 years of age or over, other than a service to which item 30615 or 30651 applies (Anaes.) (Assist.)	$1,026.60
30651	Ventral hernia repair involving primary fascial closure by suture, with or without onlay mesh or insertion of intraperitoneal onlay mesh repair, without closure of the defect or advancement of the rectus muscle toward the midline, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service associated with a service to which item 30175, 30621, 30655 or 30657 applies (H) (Anaes.) (Assist.)	$1,185.80
30652	Recurrent groin hernia regardless of size of defect, repair of, with or without mesh, by open or minimally invasive approach, in a patient 10 years of age or over (Anaes.) (Assist.)	$1,185.80
30654	Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies	$105.40
30655	Ventral hernia, repair of, with advancement of the rectus muscles to the midline using a retro-rectus, pre-peritoneal or sublay technique, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service associated with a service to which item 30175, 30621 or 30651 applies (H) (Anaes.) (Assist.)	$2,081.40
30657	Unilateral abdominal wall reconstruction with component separation, including transversus abdominus release and external oblique release for abdominal wall closure by mobilising the rectus abdominis muscles to the midline, by open or minimally invasive approach (Anaes.) (Assist.)	$2,963.80

Item No.	Description	Max Fee (excl. GST)
30658	Circumcision of the penis, when performed under general or regional anaesthesia and in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.)	$316.30
30661	Minor surgical repair following a complication from the circumcision of a penis, when performed in conjunction with a service to which an item in Group T7 or Group T10 applies, other than a service associated with a service to which item 45206 applies (H) (Anaes.)	$827.60
30662	Complex surgical repair following a complication from the circumcision of a penis, including single stage local flap, if indicated, to repair one defect, on genitals (other than a service associated with a service to which item 37819, 37822, 45200, 45201, 45202, 45203 or 45206 applies) (H) (Anaes.) (Assist.)	$1,654.70
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (H) (Anaes.)	$336.20
30666	Paraphimosis or phimosis, reduction of, under general anaesthesia, with or without dorsal incision, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$113.00
30672	COCCYX, excision of (Anaes.) (Assist.)	$1,066.10
30676	Pilonidal sinus or cyst, or sacral sinus or cyst, definitive excision of (H) (Anaes.)	$901.70
30679	Pilonidal sinus, injection of sclerosant fluid under anaesthesia (H) (Anaes.)	$215.90
30680	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (H) (Anaes.)	$2,760.00
30682	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (H) (Anaes.)	$2,760.00
30684	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, with one or more of the following procedures snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation, for diagnosis and management of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (H) (Anaes.)	$3,397.00
30686	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, with one or more of the following procedures snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation, for diagnosis and management of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (H) (Anaes.)	$3,397.00
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 (H) (Anaes.)	$1,079.30
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of one or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (H) (Anaes.)	$860.80
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 one or more of oesophageal, gastric or pancreatic cancer), not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (H) (Anaes.)	$1,329.10
30692	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of one or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (H) (Anaes.)	$860.80
30694	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration for the diagnosis of one or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (H) (Anaes.)	$1,329.10
30721	Laparotomy or laparoscopy, or laparoscopy converted to laparotomy, with or without associated biopsies, including the division of adhesions (if performed, but only if the time taken to divide adhesions is 45 minutes or less), if no other intra-abdominal procedure is performed (Anaes.) (Assist.)	$1,099.50

Item No.	Description	Max Fee (excl. GST)
30722	Laparotomy or laparoscopy, on a patient 10 years of age or over, including any of the following procedures (if performed, and including division of one or more adhesions, but only if the time taken to divide the adhesions is 45 minutes or less): (a) colostomy; (b) colotomy; (c) cholecystostomy; (d) enterostomy; (e) enterotomy; (f) gastrostomy; (g) gastrotomy; (h) caecostomy; (i) gastric fixation by cardiopexy; (j) reduction of intussusception; (k) simple repair of ruptured viscus (including perforated peptic ulcer); (l) reduction of volvulus; (m) drainage of pancreas (Anaes.) (Assist.)	$1,185.80
30723	Laparotomy, laparoscopy or extra-peritoneal approach, for drainage of an intra-abdominal, pancreatic or retroperitoneal collection or abscess (Anaes.) (Assist.)	$1,185.80
30724	Laparotomy or laparoscopy with division of adhesions, lasting more than 45 minutes but less than 2 hours, performed either: (a) as a primary procedure; or (b) when the division of adhesions is performed in conjunction with another primary procedure to provide access to a surgical field (but excluding mobilisation or normal anatomical dissection of the organ or structure for which the primary procedure is being carried out) (Anaes.) (Assist.)	$1,191.50
30725	Laparotomy or laparoscopy for intestinal obstruction or division of extensive, complex adhesions, lasting 2 hours or more, performed either:a) as a primary procedure; orb) when the division of adhesions is performed in conjunction with another procedure to provide access to a surgical field, but excluding mobilisation or normal anatomical dissection of the organ or structure for which the other procedure is being carried out (Anaes.) (Assist.)	$2,111.40
30730	Small intestine, resection of, including either of the following: (a) a small bowel diverticulum (such as Meckel s procedure) with anastomosis; (b) stricturoplasty (Anaes.) (Assist.)	$2,201.90
30731	Intraoperative enterotomy for visualisation of the small intestine by endoscopy, including endoscopic examination using a flexible endoscope, with or without biopsies (Anaes.) (Assist.)	$1,651.70
30732	Peritonectomy, lasting more than 5 hours, including hyperthermic intra-peritoneal chemotherapy (Anaes.) (Assist.)	$9,042.80
30750	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate)One surgeon (Anaes.) (Assist.)	$4,691.30
30751	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate)Conjoint surgery, principal surgeon (Anaes.) (Assist.)	$4,691.30
30752	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate)Conjoint surgery, co-surgeon (Anaes.) (Assist.)	$3,518.60
30753	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chestOne surgeon (Anaes.) (Assist.)	$3,914.90
30754	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chestConjoint surgery, principal surgeon (Anaes.) (Assist.)	$3,914.90
30755	Oesophagectomy by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chestConjoint surgery, co-surgeon (Anaes.) (Assist.)	$2,936.20
30760	Vagotomy, with or without gastroenterostomy, pyloroplasty or other drainage procedure (Anaes.) (Assist.)	$1,337.90
30762	Gastrectomy, subtotal or total radical, for carcinoma, by open or minimally invasive approach, including all necessary anastomoses, including either or both of the following (if performed): (a) extended lymph node dissection; (b) splenectomy (Anaes.) (Assist.)	$3,782.40
30763	Gastric tumour, 2cm or greater in diameter, removal of, by local excision, by endoscopic approach, including any required anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.)	$1,536.30
30771	Portal hypertension, porto-caval, meso-caval or selective spleno-renal shunt for (Anaes.) (Assist.)	$3,837.50
30790	Pancreatic cyst anastomosis to stomach, duodenum or small intestine, by endoscopic, open or minimally invasive approach, with or without the use of endoscopic or intraoperative ultrasound (Anaes.) (Assist.)	$1,595.40
30791	Pancreatic necrosectomy, by open, laparoscopic or endoscopic approach, excluding aftercare, subsequent procedure (Anaes.) (Assist.)	$991.10
30792	Distal pancreatectomy with splenectomy, by open or minimally invasive approach (Anaes.) (Assist.)	$2,716.80
30800	Splenectomy, by open or minimally invasive approach, other than a service to which item 30792 applies (Anaes.) (Assist.)	$1,638.30
30810	Exploration of pancreas or duodenum for endocrine tumour, including associated imaging, either: (a) followed by local excision of tumour; or (b) when, after extensive exploration, no tumour is found (Anaes.) (Assist.)	$2,609.80

Item No.	Description	Max Fee (excl. GST)
31000	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 6 or fewer sections (Anaes.)	$1,379.30
31001	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 7 to 12 sections (inclusive) (Anaes.)	$1,639.80
31002	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 13 or more sections (Anaes.)	$1,948.30
31003	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 6 or fewer sections Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.)	$1,265.70
31004	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 7 to 12 sections (inclusive) Not applicable to a service performed in association with a service to which item 31001 applies (Anaes.)	$1,582.00
31005	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 13 or more sections Not applicable to a service performed in association with a service to which item 31002 applies (Anaes.)	$1,898.60
31206	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.)	$216.10
31211	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 10mm, but not more than 20mm, in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.)	$278.80
31216	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 20mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.)	$324.90
31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.)	$478.90
31221	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if: (a) the size of each lesion is not more than 10mm in diameter; and (b) each removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.)	$485.70
31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.)	$855.40
31227	Tumour, lipoma or cyst, removal of single lesion by excision and suture, where removal is from subcutaneous tissue and the specimen excised is sent for histological examination (Anaes.)	$278.90
31245	Skin and subcutaneous tissue, extensive excision of, in the treatment of suppurative hydradenitis (excision from axilla, groin or natal cleft) or sycosis barbae or nuchae (excision from face or neck) (H) (Anaes.)	$883.80
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface where the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	$825.50
31340	Note: Multiple Operation and Multiple Anaesthetic rules apply to this item. Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if: (a) the specimen excised is sent for histological confirmation; and (b)a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371,31372, 31373, 31374, 31375 or 31376 is excised (Anaes.) 75% of the fee for excision of malignant tumour.	DF

Item No.	Description	Max Fee (excl. GST)
31345	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: (i) subcutaneous and 50mm or more in diameter but less than 150mm in diameter; or (ii) sub fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	$503.90
31346	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if: (a) the lesion is subcutaneous; and (b) the lesion is 50mm or more in diameter; and (c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	$493.80
31350	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient 10 years of age or over, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.)	$967.10
31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where histological proof of malignancy has been obtained, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$1,607.00
31356	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), definitive surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	$501.00
31357	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	$248.50
31358	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), definitive surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	$613.10
31359	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site); and (b) the necessary excision area is at least one third of the surface area of the applicable site; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.)	$747.20
31360	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	$380.50
31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	$422.70
31362	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	$303.20
31363	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), definitive surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	$553.10

Item No.	Description	Max Fee (excl. GST)
31364	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	$380.50
31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372, 31373, 31377, 31378 or 31379), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	$358.40
31366	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is less than 15mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	$216.10
31367	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	$483.50
31368	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is at least 15mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	$284.00
31369	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), definitive surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is more than 30mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	$556.70
31370	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is more than 30mm; and (c) the excised specimen is sent for histological examination (Anaes.)	$324.90
31371	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision of (other than by shave excision) including repair (if performed), including excision of the primary tumour bed, if: (a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	$808.10
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.)	$698.80
31373	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision of (other than by shave excision) including repair (if performed), including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	$807.50
31374	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.)	$638.30

Item No.	Description	Max Fee (excl. GST)
31375	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.)	$686.80
31376	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision of (other than by shave excision) including repair (if performed), including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is more than 30mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	$795.80
31377	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	$232.90
31378	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	$356.90
31379	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from face, neck, scalp, nipple areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	$284.30
31380	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from face, neck, scalp, nipple areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	$356.90
31381	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from any part of the body not covered by item 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is less than 15mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	$202.70
31382	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from any part of the body not covered by item 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is at least 15mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	$266.60
31383	Clinically suspected melanoma, surgical excision of (other than by shave excision) including repair (if performed), if: (a) the lesion is excised from any part of the body not covered by item 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is more than 30mm; and (c) the excised specimen is sent for histological examination (Anaes.)	$304.70
31400	Malignant upper aerodigestive tract tumour (other than tumour of the lip), excision of, if: (a) the tumour is not more than 20mm in diameter; and (b) histological confirmation of malignancy is obtained (H) (Anaes.) (Assist.)	$592.20
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	$682.80
31406	Malignant upper aerodigestive tract tumour more than 40mm in diameter (excluding tumour of the lip), excision of, if histological confirmation of malignancy has been obtained (H) (Anaes.) (Assist.)	$1,177.10
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	$3,756.80
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	$4,565.80
31423	Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a patient 10 years of age or over, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	$952.70
31426	Lymph nodes of neck, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	$1,966.90
31429	Lymph nodes of neck, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	$2,977.70

Item No.	Description	Max Fee (excl. GST)
31432	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections), other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	$3,272.90
31435	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	$2,335.40
31438	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	$3,466.90
31454	Laparoscopy or laparotomy with drainage of bile, as an independent procedure (H) (Anaes.) (Assist.)	$1,257.60
31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.)	$572.20
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.)	$686.50
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.)	$813.90
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.)	$1,163.40
31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.)	$2,942.80
31468	Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication, other than a service associated with a service to which item 30756 or 31466 applies (Anaes.) (Assist.)	$3,211.10
31472	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y loop to provide biliary drainage or bypass, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.)	$2,993.20
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 (H) (Anaes.)	$617.00
31503	Breast, benign lesion more than 50mm in diameter, excision of (H) (Anaes.) (Assist.)	$774.10
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.)	$926.20
31509	Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (H) (Anaes.)	$817.30
31512	Breast, malignant tumour, complete local excision of, with or without frozen section histology, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31513, 31514, 45520, 45522 or 45556 applies on the same side (if performed by the same medical practitioner) (H) (Anaes.) (Assist.)	$1,547.30
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.)	$983.60
31516	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiation therapy (using an Intrabeam or Xoft Axxent device) is performed concurrently, if the patient satisfies the requirements mentioned in paragraphs (a) to (g) of item 15900 Applicable only once per breast per lifetime (H) (Anaes.) (Assist.)	$2,003.80
31519	Total mastectomy (unilateral) (H) (Anaes.) (Assist.)	$1,740.40
31525	Mastectomy for gynaecomastia (unilateral), with or without liposuction (suction assisted lipolysis), if: (a) breast enlargement is not due to obesity and is not proportionate to body habitus; and (b) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes;not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)	$1,229.20
31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than 1cm in diameter;including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31548 applies	$1,421.40
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.)	$329.00
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.)	$451.90
31548	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530 applies (Anaes.)	$380.70

Item No.	Description	Max Fee (excl. GST)
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.)	$517.20
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)	$1,036.80
31557	Breast central ducts, excision of, for benign condition (H) (Anaes.) (Assist.)	$823.00
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)	$824.00
31563	Inverted nipple, surgical eversion of, with or without flap repair, if the nipple cannot readily be everted manually (Anaes.)	$640.10
31566	Accessory nipple, excision of (Anaes.)	$305.50
31569	Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1,882.50
31572	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a service to which item 30515 applies (Anaes.) (Assist.)	$2,316.40
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1,882.50
31578	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1,882.50
31581	Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$2,316.40
31584	Surgical reversal of previous bariatric procedure, including revision or conversion, if:a) the previous procedure involved any of the following: (i) placement of adjustable gastric banding; (ii) gastric bypass; (iii) sleeve gastrectomy; (iv) gastroplasty (excluding gastric plication); (v) biliopancreatic diversion; and (b) any of items 31569 to 31581 applied to the previous procedureother than a service associated with a service to which item 31585 applies (Anaes.) (Assist.)	$3,410.30
31585	Removal of adjustable gastric band (Anaes.) (Assist.)	$1,893.00
31587	Adjustment of gastric band as an independent procedure including any associated consultation	$217.00
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)	$558.00
	Colorectal	
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)	$2,472.70
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)	$2,583.50
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, 32006 or 32030 applies (H) (Anaes.) (Assist.)	$2,728.10
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004, 32006 or 32030 applies (H) (Anaes.) (Assist.)	$3,088.70
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma), other than a service associated with a service to which item 32024, 32025, 32026 or 32028 applies (H) (Anaes.) (Assist.)	$2,728.10
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.)	$3,260.90
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.)	$3,602.40
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.)	$4,170.00
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.)	$3,765.30
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.)	$1,318.50
32023	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, where the obstruction is due to: (a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or (b) an unknown diagnosis (Anaes.)	$1,258.90
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.)	$3,050.90

Item No.	Description	Max Fee (excl. GST)
32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.)	$4,367.10
32026	Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, if the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.)	$4,698.80
32028	Rectum, low or ultra-low restorative resection, with per anal sutured coloanal anastomosis, with or without covering stoma and with or without colonic reservoir, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.)	$4,996.00
32030	RECTOSIGMOIDECTOMY, including formation of stoma (H) (Anaes.) (Assist.)	$2,446.40
32033	RESTORATION OF BOWEL continuity following rectosigmoidectomy or similar operation, including dismantling of the stoma (H) (Anaes.) (Assist.)	$3,583.40
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.)	$4,582.60
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.)	$3,655.20
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.)	$3,097.70
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.)	$1,079.80
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.)	$1,778.00
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.)	$2,069.30
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.)	$5,541.30
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$5,148.20
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.)	$1,348.10
32060	Restorative proctectomy, involving rectal resection with formation of ileal reservoir and ileoanal anastomosis, including ileostomy mobilisation, with or without mucosectomy or temporary loop ileostomy, 1 surgeon (H) (Anaes.) (Assist.)	$5,541.30
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$4,978.80
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.)	$1,318.50
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)	$4,097.30
32072	Sigmoidoscopic examination (with rigid sigmoidoscope), with or without biopsy	$107.80
32075	Sigmoidoscopic examination (with rigid sigmoidoscope), under general anaesthesia, with or without biopsy, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$177.00
32084	Sigmoidoscopy or colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which any of items 32222 to 32228 or 32230 applies (H) (Anaes.)	$264.80
32087	Endoscopic examination of the colon up to the hepatic flexure by sigmoidoscopy or colonoscopy for the removal of one or more polyps, other than a service associated with a service to which any of items 32222 to 32228 or 32230 applies (H) (Anaes.)	$486.70
32094	Endoscopic dilatation of colorectal strictures including colonoscopy (Anaes.)	$1,311.00
32095	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (H) (Anaes.)	$286.00
32096	RECTAL BIOPSY, full thickness, to diagnose or exclude Hirschsprung's Disease, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.)	$590.10
32105	Anorectal carcinoma per anal full thickness excision of (H) (Anaes.) (Assist.)	$1,079.80

Item No.	Description	Max Fee (excl. GST)
32106	Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy digital viewing system and pneumorectum, if: (a) clinically appropriate; and (b) removal requires dissection within the peritoneal cavity;excluding use of a colonoscope as the operating platform and not being a service associated with a service to which item 32024, 32025 or 32232 applies (H) (Anaes.) (Assist.)	$3,257.60
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.)	$2,235.00
32117	Rectal prolapse, abdominal rectopexy of, excluding ventral mesh rectopexy, not being a service associated with a service to which item 32025 or 32026 applies (H) (Anaes.) (Assist.)	$2,639.00
32118	Treatment of external rectal prolapse, or of symptomatic high grade rectal intussusception (the rectum descends to the level of or into the anal canal, confirmed by diagnostic imaging): (a) by minimally invasive surgery involving: (i) ventral dissection of the extra-peritoneal rectum; and (ii) suspension of the rectum from the sacral promontory by means of a prosthesis; and (b) including suspension of the vagina if performed, and any associated repair; other than a service associated with a service to which item 30390, 35595 or 35597 applies (H) (Anaes.) (Assist.)	$2,709.70
32123	Anal stricture, anoplasty for (H) (Anaes.) (Assist.)	$797.70
32129	ANAL SPHINCTER, repair (H) (Anaes.) (Assist.)	$1,513.70
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.)	$1,275.30
32135	Treatment of haemorrhoids or rectal prolapse, including rubber band ligation or sclerotherapy or topical energy therapies for, not being a service to which item 32139 applies (Anaes.)	$161.70
32139	Operative treatment of symptomatic haemorrhoids, including excision of anal skin tags when performed, not being a service associated with a service to which item 32135 or 32233 applies (H) (Anaes.) (Assist.)	$872.90
32147	Perianal thrombosis, incision of (Anaes.)	$107.60
32150	Operation for anal fissure, including excision, injection of Botulinum toxin or sphincterotomy, excluding dilatation (H) (Anaes.) (Assist.)	$610.10
32156	Anal fistula, subcutaneous, excision of (H) (Anaes.)	$318.70
32159	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)	$781.80
32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.)	$1,079.80
32165	Operative treatment of anal fistula, repair by mucosal advancement flap, including ligation of inter-sphincteric fistula tract (LIFT) or other complex sphincter sparing surgery (H) (Anaes.) (Assist.)	$1,513.70
32166	Anal fistula - readjustment of Seton (Anaes.)	$494.40
32171	Anorectal examination, with or without biopsy, under general anaesthetic, with or without faecal disimpaction, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$198.50
32174	INTRA-ANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)	$209.80
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.)	$363.60
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.)	$1,339.80
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.)	$1,339.80
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.)	$318.70
32213	Sacral nerve lead or leads, placement of, percutaneous or open, including intraoperative test stimulation and programming, for the management of faecal incontinence (H) (Anaes.)	$1,576.90
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, not being a service associated with a service to which item 32213, 32216, 32218 or 32237 applies. Applicable once per day for the same patient by the same practitioner	$294.20
32216	Sacral nerve lead or leads, inserted for the management of faecal incontinence in a patient with faecal incontinence refractory to conservative non-surgical treatment, either: (a) percutaneous surgical repositioning of the lead or leads, using fluoroscopic guidance; or (b) open surgical repositioning of the lead or leads; to correct displacement or unsatisfactory positioning (including intraoperative test stimulation), not being a service associated with a service to which item 32213 applies (H) (Anaes.)	$1,415.90
32218	Sacral nerve lead or leads, removal (H) (Anaes.)	$371.70
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 (H) (Anaes.) (Assist.)	$2,003.60

Item No.	Description	Max Fee (excl. GST)
32222	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) following a positive faecal occult blood test; or (b) who has symptoms consistent with pathology of the colonic mucosa; or (c) who has anaemia or iron deficiency; or (d) for whom diagnostic imaging has shown an abnormality of the colon; or (e) who is undergoing the first examination following surgery for colorectal cancer; or (f) who is undergoing pre operative evaluation; or (g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient s previous colonoscopy; or (h) for the management of inflammatory bowel disease; other than a service associated with a service to which item 32230 applies Applicable once on a day under a single episode of anaesthesia or other sedation (H) (Anaes.)	$721.70
32223	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) who has had a colonoscopy that revealed: (i) one to 4 adenomas, each of which was less than 10mm in diameter, had no villous features and had no high grade dysplasia; or (ii) one or 2 sessile serrated lesions, each of which was less than 10mm in diameter, and without dysplasia; or (b) who has a moderate risk of colorectal cancer due to family history; or (c) who has a history of colorectal cancer and has had an initial post operative colonoscopy that did not reveal any adenomas or colorectal cancer; other than a service associated with a service to which item 32230 applies Applicable once in any 5 year period (H) (Anaes.)	$721.70
32224	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a moderate risk of colorectal cancer due to: (a) a history of adenomas, including an adenoma that: (i) was 10mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (b) having had a previous colonoscopy that revealed: (i) 5 to 9 adenomas, each of which was less than 10mm in diameter, had no villous features and had no high grade dysplasia; or (ii) one or 2 sessile serrated lesions, each of which was 10mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10mm in diameter and had no dysplasia; or (v) one or 2 traditional serrated adenomas, of any size; other than a service associated with a service to which item 32230 applies Applicable once in any 3 year period (H) (Anaes.)	$721.70
32225	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to having had a previous colonoscopy that: (a) revealed 10 or more adenomas; or (b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp; other than a service associated with a service to which item 32230 applies Applicable 4 times in any 12 month period (H) (Anaes.)	$721.70
32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to: (a) having either: (i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (ii) a genetic mutation associated with hereditary colorectal cancer; or (b) having had a previous colonoscopy that revealed: (i) 5 or more sessile serrated lesions, each of which was less than 10mm in diameter and had no dysplasia; or (ii) 3 or more sessile serrated lesions, one or more of which was 10mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size; other than a service associated with a service to which item 32230 applies Applicable once in any 12 month period (H) (Anaes.)	$721.70
32227	Endoscopic examination of the colon to the caecum by colonoscopy: (a) for the treatment of bleeding, including one or more of the following: (i) radiation proctitis; (ii) angioectasia; (iii) post polypectomy bleeding; or (b) for the treatment of colonic strictures with balloon dilatation Applicable only once on a day under a single episode of anaesthesia or other sedation (H) (Anaes.)	$1,012.60
32228	Endoscopic examination of the colon to the caecum by colonoscopy, other than: (a) a service to which item 32222, 32223, 32224, 32225 or 32226 applies; or (b) a service associated with a service to which item 32230 applies Applicable once (H) (Anaes.)	$721.70
32229	Removal of one or more polyps during colonoscopy, in association with a service to which item 32222, 32223, 32224, 32225, 32226 or 32228 applies (H) (Anaes.)	$582.10
32230	Endoscopic mucosal resection using electrocautery of a non invasive sessile or flat superficial colorectal neoplasm which is at least 25mm in diameter, if the service is supported by photographic evidence to confirm the size of the polyp in situ Applicable once per polyp (H) (Anaes.)	$1,476.90
32231	Rectal tumour, per anal excision of (H) (Anaes.) (Assist.)	$718.90
32232	Rectal tumour, per anal excision of, using a rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, not being a service associated with a service to which item 32024, 32025 or 32106 applies (H) (Anaes.) (Assist.)	$1,948.80
32233	Perineal repair of rectal prolapse, not being a service associated with a service to which item 32139 applies (H) (Anaes.) (Assist.)	$1,384.30
32234	Rectal stricture, treatment of (H) (Anaes.)	$273.60
32235	Anal skin tags or anal polyps, excision of one or more of (Anaes.)	$264.20
32236	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block), not being a service associated with a service to which item 35507 or 35508 applies (H) (Anaes.)	$375.90

Item No.	Description	Max Fee (excl. GST)
32237	Neurostimulator or receiver, subcutaneous placement of, replacement of, or removal of, including programming and placement and connection of an extension wire or wires to sacral nerve electrode (s), for the management of faecal incontinence (H) (Anaes.) (Assist.)	$609.60
	Vascular	
32500	Varicose veins, multiple injections of sclerosant using continuous compression techniques, including associated consultation, one or both legs, if: (a) proximal reflux of 0.5 seconds or longer has been demonstrated; and (b) the service is not for cosmetic purposes; and (c) the service is not associated with: (i) any other varicose vein operation on the same leg (excluding aftercare); or (ii) a service on the same leg (excluding aftercare) to which any of the following items apply: (A) 35200; (B) 59970 to 60078; (C) 60500 to 60509; (D) 61109 Applicable to a maximum of 6 treatments in a 12 month period (Anaes.)	$262.30
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.)	$655.60
32507	Varicose veins, sub fascial ligation of one or more incompetent perforating veins in one leg of a patient, if the service: (a) is performed by open surgical technique (not including endoscopic ligation) and the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; and (b) is not associated with: (i) any other varicose vein operation on the same leg; or (ii) a service (on the same leg) to which item 35200, 60072, 60075 or 60078 applies (H) (Anaes.) (Assist.)	$1,265.60
32508	Varicose veins, complete dissection at the sapheno femoral or sapheno popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	$1,191.30
32511	Varicose veins, complete dissection at the sapheno femoral and sapheno popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	$1,874.20
32514	Varicose veins, ligation of the great or small saphenous vein in the same leg of a patient, with or without stripping, by re operation for recurrent veins in the same territory one leg including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	$2,213.10
32517	Varicose veins, ligation of the great and small saphenous vein in the same leg of a patient, with or without stripping, by re operation for recurrent veins in either territory one leg including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	$2,738.40
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) of the patient demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	$1,253.30

Item No.	Description	Max Fee (excl. GST)
32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins of the patient demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	$1,863.10
32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	$1,209.50
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	$1,798.40
32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service include all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	$1,188.80
32529	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	$1,767.50
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)	$3,441.30
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)	$2,828.00
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.)	$3,371.10
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.)	$3,652.80

Item No.	Description	Max Fee (excl. GST)
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.)	$3,879.80
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.)	$2,802.60
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.)	$2,940.60
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)	$2,652.30
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.)	$4,520.10
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.)	$4,781.20
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.)	$3,628.60
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.)	$4,520.10
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.)	$981.90
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.)	$2,887.30
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.)	$3,308.50
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.)	$3,778.10
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.)	$4,389.90
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.)	$2,652.30
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.)	$3,308.50
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.)	$968.00
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.)	$963.90
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$2,652.30
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.)	$2,499.80
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.)	$648.90
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.)	$3,250.00
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)	$2,608.50
33070	Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	$1,879.10
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2,392.70
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2,918.20
33100	Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (H) (Anaes.) (Assist.)	$3,441.30
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$4,829.70
33109	Thoraco abdominal aneurysm, replacement by graft including re implantation of arteries (H) (Anaes.) (Assist.)	$5,443.80
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)	$5,055.30
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.)	$3,379.20

Item No.	Description	Max Fee (excl. GST)
33116	Infrarenal abdominal aortic aneurysm (repair), replacement by tube graft using endovascular repair procedure, excluding associated radiological services (H) (Anaes.) (Assist.)	$3,181.20
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.)	$3,764.50
33119	Infrarenal abdominal aortic aneurysm (repair), replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (H) (Anaes.) (Assist.)	$3,694.60
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) (Anaes.) (Assist.)	$4,063.10
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.)	$2,898.50
33127	Aneurysms of iliac arteries (common, external or internal), replacement by graft bilateral (H) (Anaes.) (Assist.)	$3,715.50
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.)	$3,309.00
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.)	$2,485.30
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.)	$6,274.70
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)	$3,542.80
33142	False aneurysm, repair of, in femoral artery and restoration of arterial continuity (H) (Anaes.) (Assist.)	$3,308.50
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$6,087.10
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$7,412.90
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$7,212.50
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.)	$4,972.50
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)	$5,548.10
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.)	$6,467.10
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)	$4,997.20
33166	Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (H) (Anaes.) (Assist.)	$4,930.80
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)	$3,838.80
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$3,057.10
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2,628.70
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$3,347.00
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$4,092.00
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.)	$2,693.10
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.)	$2,975.70
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.)	$3,375.70
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.)	$3,563.80
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.)	$4,143.90
33518	Iliac endarterectomy, including closure by suture, other than a service associated with another procedure on the iliac artery (H) (Anaes.) (Assist.)	$3,029.90
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)	$3,282.50

Item No.	Description	Max Fee (excl. GST)
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.)	$3,628.60
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.)	$4,520.10
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)	$3,628.60
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)	$4,419.50
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$3,151.80
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.)	$2,305.00
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.)	$3,311.40
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.)	$650.60
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.)	$1,241.80
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.)	$650.60
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.)	$646.00
33800	Embolus, removal of, from artery of neck (H) (Anaes.) (Assist.)	$2,822.40
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.)	$2,680.20
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 (H) (Anaes.) (Assist.)	$1,815.20
33810	Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (H) (Anaes.) (Assist.)	$1,342.60
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.)	$4,196.80
33812	Thrombus, removal of, from femoral or other similar large vein (H) (Anaes.) (Assist.)	$2,232.70
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)	$2,036.30
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)	$2,374.40
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)	$2,574.60
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)	$2,592.50
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)	$3,027.30
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)	$3,553.50
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.)	$3,188.60
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)	$3,542.80
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.)	$4,437.00
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.)	$2,175.00
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.)	$1,428.00
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.)	$1,428.00
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.)	$1,578.70

Item No.	Description	Max Fee (excl. GST)
34103	Great artery (aorta or pulmonary artery) or great vein (superior or inferior vena cava), ligation or exploration of immediate branches or tributaries, or ligation or exploration of the subclavian, axillary, iliac, femoral or popliteal arteries or veins, if the service is not associated with item 32508, 32511, 32520, 32522, 32523, 32526, 32528 or 32529 - for a maximum of 2 services provided to the same patient on the same occasion (H) (Anaes.) (Assist.)	$982.00
34106	Artery or vein (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, other than a service associated with another vascular procedure except those services to which item 32508, 32511, 32514 or 32517 applies (H) (Anaes.) (Assist.)	$718.60
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.)	$803.40
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.)	$2,054.30
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.)	$2,305.00
34118	Arterio venous fistula of the abdomen, dissection and ligation (H) (Anaes.) (Assist.)	$3,239.70
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)	$2,469.50
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)	$2,835.10
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)	$3,715.50
34130	Surgically created arterio venous fistula of an extremity, closure of (H) (Anaes.) (Assist.)	$1,180.00
34133	SCALENOTOMY (Anaes.) (Assist.)	$1,243.70
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.)	$2,016.20
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$2,139.20
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.)	$2,690.00
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.)	$1,822.10
34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)	$3,545.60
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)	$4,689.30
34154	Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (H) (Anaes.) (Assist.)	$5,224.00
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)	$2,782.50
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.)	$5,212.20
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.)	$6,691.30
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.)	$6,436.70
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.)	$3,542.80
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.)	$2,887.30
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.)	$2,652.30
34500	Arteriovenous shunt, external, insertion of (H) (Anaes.) (Assist.)	$721.90
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.)	$984.20
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.)	$500.10
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.)	$2,335.70
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.)	$2,398.90
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.)	$1,837.80
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.)	$2,870.40

Item No.	Description	Max Fee (excl. GST)
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.)	$1,610.70
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.)	$922.60
34527	Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient 10 years of age or over (H) (Anaes.)	$1,276.50
34528	Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient 10 years of age or over (H) (Anaes.)	$608.70
34529	Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient under 10 years of age (H) (Anaes.)	$1,657.40
34530	Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a patient 10 years of age or over (H) (Anaes.)	$489.50
34533	Isolated limb perfusion, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding after care) (H) (Anaes.) (Assist.)	$2,960.20
34534	Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient under 10 years of age (H) (Anaes.)	$818.50
34538	Central vein catheterisation by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (H) (Anaes.)	$619.70
34539	Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure (Anaes.)	$464.80
34540	Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a patient under 10 years of age (H) (Anaes.)	$613.80
34800	Inferior vena cava, plication, ligation, or application of caval clip (H) (Anaes.) (Assist.)	$1,917.20
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.)	$4,105.50
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.)	$2,271.50
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.)	$2,271.50
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.)	$2,643.80
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.)	$2,305.00
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.)	$2,382.30
34821	Vein transplant to restore valvular function (H) (Anaes.) (Assist.)	$3,398.60
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.)	$1,232.60
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.)	$1,351.50
34830	External stent, application of, to restore venous valve competency to deep vein one stent (H) (Anaes.) (Assist.)	$1,655.40
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.)	$2,148.00
35000	Lumbar sympathectomy (H) (Anaes.) (Assist.)	$1,578.70
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.)	$2,039.20
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.)	$2,731.80
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.)	$2,123.30
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)	$1,684.00
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.)	$877.40
35103	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.)	$556.00

Item No.	Description	Max Fee (excl. GST)
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.)	$407.90
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.)	$1,824.00
35300	Transluminal balloon angioplasty of one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	$1,224.50
35303	Transluminal balloon angioplasty of aortic arch branches, aortic visceral branches, or more than one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after care (H) (Anaes.) (Assist.)	$1,572.20
35306	Transluminal stent insertion, one or more stents, including associated balloon dilatation for one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.)	$1,461.00
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 (Anaes.) (Assist.)	$2,674.60
35309	Transluminal stent insertion, one or more stents, including associated balloon dilatation for visceral arteries or veins, or more than one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	$1,809.30
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$2,053.30
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$1,960.50
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	$845.00
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 after-care (other than a service associated with a service to which an item in Subgroup 11 of Group T1 or item 35317 or 35320 applies, or associated with photodynamic therapy with verteporfin) (H) (Anaes.) (Assist.)	$1,524.10
35320	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by open exposure, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with a service to which an item in Subgroup 11 of Group T1 or item 35317 or 35319 applies, or associated with photodynamic therapy with verteporfin) (H) (Anaes.) (Assist.)	$1,939.20
35321	Peripheral arterial or venous catheterisation to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage (but not for the treatment of uterine fibroids or varicose veins), percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with photodynamic therapy with verteporfin) (H) (Anaes.) (Assist.)	$1,930.90
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$724.60
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$956.90
35330	Insertion of inferior vena caval filter, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	$1,232.40
35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.)	$1,322.10
35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1,939.30
35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1,585.10

Item No.	Description	Max Fee (excl. GST)
35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1,322.10
35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1,137.60
35401	Vertebroplasty, for one or more fractures in one or more vertebrae, for the treatment of a painful osteoporotic thoracolumbar vertebral compression fracture of the thoracolumbar spinal segment (T11, T12, L1 or L2), if: (a) the service is performed by a specialist or consultant physician practicing in the specialist's or consultant physician's speciality of diagnostic radiology, neurosurgery, neurology or orthopaedic surgery; and (b) the specialist or consultant physician has undertaken appropriate training in the vertebroplasty procedure; and (c) pain is severe (numeric rated pain score greater than or equal to 7 out of 10); and (d) the symptoms are poorly controlled by opiate therapy; and (e) the severe pain duration is 3 weeks or less; and (f) there is MRI (or SPECT CT if MRI unavailable) evidence of acute vertebral fracture Applicable only once for the same fracture, but is applicable for a new fracture of the same vertebra or vertebrae (H) (Anaes.)	$1,509.20
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.	$807.50
35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$1,894.90
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$1,421.30
35410	Uterine artery catheterisation with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (H) (Anaes.) (Assist.)	$1,894.90
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling (if performed), with parent artery preservation, not for use with liquid embolics only, including intra operative imaging, but in association with pre operative diagnostic imaging under item 60009 and one of items 60072, 60075 and 60078, including aftercare (H) (Anaes.) (Assist.)	$6,657.40
35414	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic stroke caused by occlusion of a large vessel of the anterior cerebral circulation, including intra-operative imaging and aftercare, if: (a) the diagnosis is confirmed by an appropriate imaging modality such as computed tomography, magnetic resonance imaging or angiography; and (b) the service is performed by a specialist or consultant physician with appropriate training that is recognised by the Conjoint Committee for Recognition of Training in Interventional Neuroradiology; and (c) the service is provided in an eligible stroke centre. For any particular patient - applicable once per presentation by the patient at an eligible stroke centre, regardless of the number of times mechanical thrombectomy is attempted during that presentation (Anaes.) (Assist.)	$7,797.80
	Gynaecological	
35500	Gynaecological examination under anaesthesia, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$193.00
35503	Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy, if the service is not associated with a service to which another item in this Group applies (other than a service described in item 30062, 35501, 35506 or 35620) (Anaes.)	$141.10
35506	Intra-uterine device, removal of under general anaesthesia, for a retained or embedded device, not being a service associated with a service to which another item in this Group applies (other than a service described in item 35501 or 35503) (H) (Anaes.)	$120.40
35507	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is less than or equal to 45 minutes other than a service associated with a service to which item 32236 applies (H) (Anaes.)	$416.70
35508	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is greater than 45 minutes other than a service associated with a service to which item 32236 applies (H) (Anaes.) (Assist.)	$609.50

Item No.	Description	Max Fee (excl. GST)
35509	Hymenectomy (Anaes.)	$211.80
35513	Bartholin's abscess, cyst or gland, excision of (Anaes.)	$494.80
35517	Bartholin's abscess, cyst or gland, marsupialisation of (Anaes.)	$331.70
35518	Ovarian cyst aspiration, for cysts of at least 4cm in diameter in a premenopausal patient and at least 2cm in diameter in a postmenopausal patient, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques, and not in cases of suspected or possible malignancy (Anaes.)	$463.90
35527	Urethral caruncle, symptomatic excision of, if: (a) conservative management has failed; or (b) there is a suspicion of malignancy (H) (Anaes.)	$355.70
35533	Vulvoplasty or labioplasty, for repair of: (a) female genital mutilation; or (b) an anomaly associated with a major congenital anomaly of the uro-gynaecological tract other than a service associated with a service to which item 35536, 37836, 37050, 37842, 37851 or 43882 applies (Anaes.)	$797.20
35534	Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a specialist in the practice of the specialist's specialty, for a structural abnormality that is causing significant functional impairment, if the patient's labium extends more than 8cm below the vaginal introitus while the patient is in a standing resting position (Anaes.)	$827.30
35536	Vulva, wide local excision or hemivulvectomy, one or both procedures, for suspected malignancy or vulval lesions with a high risk of malignancy (H) (Anaes.) (Assist.)	$827.50
35539	Colposcopically directed laser therapy for histologically-confirmed high grade intraepithelial neoplastic changes of the vagina, vulva, urethra or anal canal, including any associated biopsies one anatomical site (Anaes.)	$648.40
35545	Colposcopically directed laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)	$427.90
35548	VULVECTOMY, radical, for malignancy (H) (Anaes.) (Assist.)	$2,192.50
35551	Pelvic lymph nodes, radical excision of, unilateral, or sentinel node dissection (including any pre-operative injection) (Anaes.) (Assist.)	$2,020.80
35552	Pelvic lymph nodes, radical excision of, unilateral or sentinel node dissection, following similar previous dissection, radiation or chemotherapy (H) (Anaes.) (Assist.)	$3,047.20
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.)	$101.20
35557	Vagina, complete excision of benign tumour (including Gartner duct cyst), with histological documentation (Anaes.)	$509.80
35560	Partial or complete vaginectomy, for either or both of the following: (a) deeply infiltrating vaginal endometriosis, if accompanied by histological confirmation from excised tissue; (b) pre-invasive or invasive lesions Not being a service associated with hysterectomy for non invasive indications (H) (Anaes.) (Assist.)	$1,627.50
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (H) (Anaes.) (Assist.)	$3,600.00
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (H) (Anaes.) (Assist.)	$2,898.10
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (H) (Assist.)	$1,517.30
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.)	$1,606.00
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.)	$886.40
35568	Procedures for the management of symptomatic upper vaginal (vault or cervical) prolapse by sacrospinous or ilococcygeus fixation (H) (Anaes.) (Assist.)	$1,486.50
35569	Plastic repair to enlarge vaginal orifice (Anaes.)	$358.90
35570	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of urethrocele and cystocele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)	$1,317.60
35571	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of one or more of the following: (i) perineum; (ii) rectocoele; (iii) enterocoele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)	$1,313.60
35573	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving anterior and posterior compartment defects; and (b) using native tissue without graft; other than a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.)	$1,989.10
35577	Manchester (Donald Fothergill) operation for pelvic organ prolapse, involving either or both of the following: (a) cervical amputation; (b) anterior and posterior native tissue vaginal wall repairs without graft (Anaes.) (Assist.)	$1,610.80

Item No.	Description	Max Fee (excl. GST)
35578	Colpocleisis for pelvic organ prolapse, not being a service associated with a service to which another item (other than item 35599) in this Subgroup applies (H) (Anaes.) (Assist.)	$1,507.90
35581	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), less than $2cm^2$ in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies (Anaes.) (Assist.)	$1,233.90
35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), $2cm^2$ or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies (Anaes.) (Assist.)	$1,851.30
35585	Abdominal procedure, by open, laparoscopic or robot assisted approach, if the service: (a) is for the removal of graft material: (i) in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure); or (ii) where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel; and (b) if required includes retroperitoneal dissection, and mobilisation, of either or both of the bladder and bowel; other than a service associated with a service to which item 35581 or 35582 applies (Anaes.) (Assist.)	$3,282.20
35591	Rectovaginal fistula repair of, by vaginal route approach, not being a service associated with a service to which item 35592, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	$1,963.30
35592	Vesicovaginal fistula closure of, by vaginal approach, not being a service associated with a service to which item 35591, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	$1,963.30
35595	Procedure for the management of symptomatic vaginal vault or cervical prolapse, by uterosacral ligament suspension, by any approach, without graft, if the uterosacral ligaments are separately identified, transfixed and then incorporated into rectovaginal and pubocervical fascia of the vaginal vault, including cystoscopy to check ureteric integrity (H) (Anaes.) (Assist.)	$2,019.30
35596	Fistula between genital and urinary or alimentary tracts, repair of, other than a service to which item 35591, 35592, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	$1,788.40
35597	Sacral colpopexy, by any approach where graft or mesh is secured to vault, anterior and posterior compartments and to sacrum for correction of symptomatic upper vaginal vault prolapse (H) (Anaes.) (Assist.)	$3,385.50
35599	Stress incontinence, procedure using a female synthetic mid-urethral sling, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, other than a service associated with a service to which item 36812 applies (H) (Anaes.) (Assist.)	$1,839.20
35608	Cervix, one or more biopsies, cauterisation (other than by chemical means), ionisation, diathermy or endocervical curettage of, with or without dilatation of cervix (Anaes.)	$152.80
35609	Cervix, cone biopsy or amputation (H) (Anaes.)	$462.70
35610	Cervix, cone biopsy for histologically proven malignancy (H) (Anaes.)	$809.90
35611	Removal of cervical or vaginal polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.)	$151.70
35612	Cervix, residual stump, removal of, by abdominal approach for non-malignant lesions (H) (Anaes.) (Assist.)	$1,129.80
35614	Examination of the lower genital tract using a colposcope in a patient who: (a) has a human papilloma virus related gynaecology indication; or (b) has symptoms or signs suspicious of lower genital tract malignancy; or (c) is undergoing follow-up treatment of lower genital tract malignancy; or (d) is undergoing assessment or surveillance of a vulvovaginal pre-malignant or malignant disease; or (e) is undergoing assessment or surveillance as part of an identified at risk population	$151.90
35615	Vulva or vagina, biopsy of, when performed in conjunction with a service to which item 35614 applies	$140.50
35616	Endometrial ablation by thermal balloon or radiofrequency electrosurgery, for abnormal uterine bleeding, with or without endometrial sampling, including any hysteroscopy performed on the same day (H) (Anaes.)	$1,003.50
35620	Endometrial biopsy for pathological assessment in women with abnormal uterine bleeding or post-menopausal bleeding (Anaes.)	$119.30
35622	Endometrial ablation, using hysteroscopically guided electrosurgery or laser energy for abnormal uterine bleeding, with or without endometrial sampling, not being a service associated with a service to which item 30390 applies (H) (Anaes.)	$1,428.80
35623	Endometrial ablation and resection of myoma or uterine septum (or both), using hysteroscopic guided electrosurgery or laser energy, for abnormal uterine bleeding, with or without endometrial sampling (H) (Anaes.)	$1,952.70
35626	Hysteroscopy for investigation of suspected intrauterine pathology, with or without local anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35630 applies	$218.30
35630	Hysteroscopy for investigation of suspected intrauterine pathology if performed under general anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35626 applies (H) (Anaes.)	$417.20

Item No.	Description	Max Fee (excl. GST)
35631	Operative laparoscopy, including any of the following: (a) unilateral or bilateral ovarian cystectomy; (b) salpingo-oophorectomy; (c) salpingectomy for tubal pathology (including ectopic pregnancy by tubal removal or salpingostomy, but excluding sterilisation); (d) excision of mild endometriosis;not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725) applies (H) (Anaes.) (Assist.)	$1,510.60
35632	Complicated operative laparoscopy, including either or both of the following: (a) excision of moderate endometriosis; (b) laparoscopic myomectomy for a myoma of at least 4cm, including incision and repair of the uterus;not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725 or 35658) applies (H) (Anaes.) (Assist.)	$1,888.20
35633	Hysteroscopy, under visual guidance, including any of the following: (a) removal of an intra-uterine device; (b) removal of polyps by any method; (c) division of minor intrauterine adhesions (Anaes.)	$520.60
35635	Hysteroscopy involving division of: (a) a uterine septum; or (b) moderate to severe intrauterine adhesions (H) (Anaes.)	$791.60
35636	Hysteroscopy, resection of myoma or myoma and uterine septum (if both are performed) (H) (Anaes.)	$1,053.80
35637	Operative laparoscopy, including any of the following: (a) excision or ablation of minimal endometriosis; (b) division of pathological adhesions; (c) sterilisation by application of clips, division, destruction or removal of tubes; not being a service associated with another laparoscopic procedure (H) NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Anaes.) (Assist.)	$908.60
35640	Uterus, curettage of, with or without dilation (including curettage for incomplete miscarriage), if performed under: (a) general anaesthesia; or (b) epidural or spinal (intrathecal) nerve block; or (c) sedation;including procedures (if performed) to which item 35626 or 35630 applies (Anaes.)	$435.10
35641	Severe endometriosis, laparoscopic resection of, involving 2 of the following procedures: (a) resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter; (b) resection of the Pouch of Douglas; (c) resection of an ovarian endometrioma greater than 2cm in diameter; (d) dissection of bowel from uterus from the level of the endocervical junction or above (H) (Anaes.) (Assist.)	$2,819.60
35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage, if performed under: (a) local anaesthesia; or (b) general anaesthesia; or (c) epidural or spinal (intrathecal) nerve block; or (d) sedation;including procedures (if performed) to which item 35626 or 35630 applies (Anaes.)	$507.60
35644	Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia and biopsies, for previously biopsy confirmed HSIL (CIN 2/3) in a patient with a Type 1 or 2 (completely visible) transformation zone, if there is: (a) no evidence of invasive or glandular disease; and (b) no discordance between cytology and previous histology;not being a service associated with a service to which item 35647 or 35648 applies (Anaes.)	$474.60
35645	Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia or biopsies, in conjunction with ablative therapy of additional areas of biopsy proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus, for previously biopsy confirmed HSIL (CIN2/3) in a patient with a Type 1 of 2 (completely visible) transformation zone, if there is: (a) no evidence of invasive or glandular disease; and (b) no discordance between cytology and previous histology;not being a service associated with a service to which item 35647 or 35648 applies (Anaes.)	$755.80
35647	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies (Anaes.)	$471.00
35648	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of biopsy-proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus (Anaes.)	$712.80
35649	Myomectomy, one or more myomas, when undertaken by an open abdominal approach (H) (Anaes.) (Assist.)	$1,215.50
35653	Hysterectomy, abdominal, with or without removal of fallopian tubes and ovaries (H) (Anaes.) (Assist.)	$1,599.70
35657	Hysterectomy, vaginal, with or without uterine curettage, inclusive of posterior culdoplasty, not being a service associated with a service to which item 35673 applies (H) (Anaes.) (Assist.)	$1,506.00
35658	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal or laparoscopic removal at hysterectomy or myoma of at least 4cm removed by laparoscopy when retrieved from the abdomen (H) (Anaes.) (Assist.)	$940.70
35661	Hysterectomy, abdominal, that concurrently requires extensive retroperitoneal dissection with exposure of one or both ureters and complex side wall dissection, including when performed with one or more of the following procedures: (a) salpingectomy; (b) oophorectomy; (c) excision of ovarian cyst (H) (Anaes.) (Assist.)	$2,329.40
35667	Radical hysterectomy or radical trachelectomy (with or without excision of uterine adnexae) for proven malignancy, including excision of any one or more of the following: (a) parametrium; (b) paracolpos; (c) upper vagina; (d) contiguous pelvic peritoneum;utilising nerve sparing techniques and involving ureterolysis, if performed (H) (Anaes.) (Assist.)	$3,229.50

Item No.	Description	Max Fee (excl. GST)
35668	Hysterectomy, radical (with or without excision of uterine adnexae) including excision of any one or more of the following: (a) parametrium; (b) paracolpos; (c) upper vagina; (d) contiguous pelvic peritoneum;utilising nerve sparing techniques and involving ureterolysis, if performed in a patient with malignancy and previous pelvic radiation or chemotherapy treatment (H) (Anaes.) (Assist.)	$3,930.50
35669	Hysterectomy, peripartum, performed for histologically proven placenta increta or percreta, or placenta accreta, if the patient has been referred to another practitioner for the management of severe intractable peripartum haemorrhage (H) (Anaes.) (Assist.)	$3,930.50
35671	Hysterectomy, peripartum, for ongoing intractable haemorrhage where other haemorrhage control techniques have failed, for the purpose of providing lifesaving emergency treatment, not being a service associated with a service to which item 35667, 35668 or 35669 applies (H) (Anaes.) (Assist.)	$3,083.40
35673	Hysterectomy, vaginal, with or without uterine curettage, with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides, inclusive of a posterior culdoplasty, not being a service associated with a service to which item 35657 applies (H) (Anaes.) (Assist.)	$1,802.00
35674	Ultrasound guided needling and injection of ectopic pregnancy (H)	$484.50
35680	Bicornuate uterus, plastic reconstruction for (H) (Anaes.) (Assist.)	$1,406.80
35691	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim. (Anaes.) (Assist.)	$379.60
35694	Tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	$1,516.00
35697	Microsurgical or laparoscopic tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)	$2,263.20
35700	FALLOPIAN TUBES, unilateral microsurgical or laparoscopic anastomosis of (H) (Anaes.) (Assist.)	$1,652.20
35703	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure (Anaes.)	$155.30
35717	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst one or more such procedures, unilateral or bilateral, including adhesiolysis, for benign disease (including ectopic pregnancy by tubal removal or salpingostomy), not being a service associated with hysterectomy (H) (Anaes.) (Assist.)	$1,421.00
35720	Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the pelvic cavity, including resection of peritoneum from the following: (a) the pelvic side wall; (b) the pouch of Douglas; (c) the bladder;for macroscopic disease confined to the pelvis, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.)	$1,788.90
35721	Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the abdominal and pelvic cavity, where cancer has extended beyond the pelvis, including any of the following: (a) resection of peritoneum over any of the following: (i) the diaphragm; (ii) the paracolic gutters; (iii) the greater or lesser omentum; (iv) the porta hepatis; (b) cytoreduction of recurrent gynaecological malignancy from the abdominal cavity following previous abdominal surgery, radiation or chemotherapy; (c) cytoreduction of recurrent gynaecological malignancy from the pelvic cavity following previous pelvic surgery, radiation or chemotherapy;not being a service to which a service associated with a service to which item 35720 or 35726 applies (H) (Anaes.) (Assist.)	$6,772.60
35723	Para-aortic lymph node dissection from above the level of the aortic bifurcation (unilateral), for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)	$1,283.50
35724	Para-aortic lymph node dissection (pelvic or above the aortic bifurcation) after prior similar dissection, radiotherapy or chemotherapy for malignancy (H) (Anaes.) (Assist.)	$4,430.50
35726	Infra-colic omentectomy, with or without multiple peritoneal biopsies, for staging or restaging of gynaecological malignancy, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.)	$1,104.10
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)	$501.80
35730	Ovarian repositioning for one or both ovaries to preserve ovarian function, prior to gonadotoxic radiotherapy when the treatment volume and dose of radiation have a high probability of causing infertility (Anaes.)	$485.40
35750	Hysterectomy, laparoscopic assisted vaginal, by any approach, including any endometrial sampling, with or without removal of the tubes or ovarian cystectomy or removal of the ovaries and tubes due to other pathology, not being a service associated with a service to which item 35595 or 35673 applies. (H) (Anaes.) (Assist.)	$1,789.60
35751	Hysterectomy, laparoscopic, by any approach, including any endometrial sampling, with or without removal of the tubes, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.)	$1,665.90

Item No.	Description	Max Fee (excl. GST)
35753	Hysterectomy, complex laparoscopic, by any approach, including endometrial sampling, with either or both of the following procedures: (a) unilateral or bilateral salpingo-oophorectomy (excluding salpingectomy); (b) excision of moderate endometriosis or ovarian cyst;including any associated laparoscopy, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.)	$2,100.20
35754	Hysterectomy, complex laparoscopic, by any approach, that concurrently requires either extensive retroperitoneal dissection or complex side wall dissection, or both, with any of the following procedures (if performed): (a) endometrial sampling; (b) unilateral or bilateral salpingectomy, oophorectomy or salpingo-oophorectomy; (c) excision of ovarian cyst; (d) any other associated laparoscopy; not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.)	$3,287.10
35756	Hysterectomy, laparoscopic, by any approach, if the procedure is completed by open hysterectomy for control of bleeding or extensive pathology, including any associated laparoscopy, not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.)	$2,049.00
35759	Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal, abdominal or laparoscopic approach if no other procedure is performed (H) (Anaes.) (Assist.)	$1,345.70
	Urological	
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.)	$1,547.30
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.)	$3,120.70
36504	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with biopsy of bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203 or 37215 applies (H) (Anaes.)	$642.40
36505	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies. (Anaes.)	$504.90
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.)	$2,077.50
36507	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36840 or 36845 applies (H) (Anaes.)	$845.90
36508	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter, not being a service to which item 36845 applies (H) (Anaes.)	$1,648.20
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.)	$1,857.50
36516	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2,196.90
36519	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, complicated by previous surgery on the same kidney, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3,068.80
36522	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2,636.90
36525	Nephrectomy, partial, by open, laparoscopic or robot assisted approach: (a) if complicated by previous surgery or ablative procedure on the same kidney; or (b) for a patient with a solitary functioning kidney; or (c) for a patient with an estimated glomerular filtration rate (eGFR) of less than 60ml/min/1.73m2; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3,733.20
36528	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3,075.50
36529	Nephrectomy, radical, by open, laparoscopic or robot assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy: (a) for a tumour 10cm or more in diameter; or (b) if complicated by previous open or laparoscopic surgery on the same kidney; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3,720.60
36530	Renal cell carcinoma, not more than 4cm in diameter, destruction of, by percutaneous, laparoscopic or open cryoablation (including any associated imaging services), if: (a) malignancy has previously been confirmed by histopathological examination; and (b) a multi disciplinary team has reviewed treatment options for the patient and assessed that partial nephrectomy is not suitable; and (c) the service is not a service associated with a service to which item 36522 or 36525 applies (H) (Anaes.)	$1,746.80
36531	Nephroureterectomy, complete, by open, laparoscopic or robot-assisted approach, including associated bladder repair and any associated endoscopic procedure, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2,735.70

Item No.	Description	Max Fee (excl. GST)
36532	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, other than a service to which item 36533 applies or a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3,864.00
36533	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, if complicated by previous open or laparoscopic surgery on the same kidney or ureter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$4,678.40
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$1,649.90
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for one or more renal stones, including one or more of nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (H) (Anaes.) (Assist.)	$2,887.80
36546	Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and post treatment care for 3 days, including pre treatment consultations, unilateral (H) (Anaes.)	$1,640.80
36549	Ureterolithotomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	$1,993.30
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)	$1,664.10
36558	Renal cyst or cysts, excision or unroofing of (H) (Anaes.) (Assist.)	$1,540.60
36561	Renal biopsy, performed under image guidance (closed) (Anaes.)	$406.90
36564	Pyeloplasty, (plastic reconstruction of the pelvi-ureteric junction) by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.)	$2,198.40
36567	Pyeloplasty in a kidney that is congenitally abnormal (in addition to the presence of pelvi-ureteric junction obstruction), or in a solitary kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.)	$2,283.80
36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.)	$3,075.50
36573	DIVIDED URETER, repair of (Anaes.) (Assist.)	$2,208.70
36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, by open, laparoscopic or robot assisted approach, other than a service associated with: (a) any other procedure performed on the kidney, renal pelvis or renal pedicle; or (b) a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2,746.50
36579	Ureterectomy, complete or partial: (a) for a tumour within the ureter, proven by histopathology at the time of surgery; or (b) for congenital anomaly; with or without associated bladder repair (Anaes.) (Assist.)	$1,759.90
36585	URETER, transplantation of, into skin (Anaes.) (Assist.)	$1,736.50
36588	URETER, reimplantation into bladder (Anaes.) (Assist.)	$2,077.50
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.)	$2,497.10
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.)	$2,069.60
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.)	$2,208.80
36600	Ureter, transplantation of, into isolated intestinal segment, unilateral (H) (Anaes.) (Assist.)	$2,476.10
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.)	$3,063.60
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (H) (Anaes.)	$639.10
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.)	$5,180.00
36607	Ureteric stent insertion of, with balloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional radiology techniques, but not including imaging (Anaes.)	$1,556.70
36608	Ureteric stent, exchange of, percutaneously through either the ileal conduit or bladder, using interventional radiology techniques, but not including imaging, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.)	$639.20
36609	Intestinal urinary conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.)	$1,776.50
36610	Intestinal urinary conduit, incontinent, formation of (including associated small bowel resection and anastomosis), including implantation of one or both ureters into reservoir (Anaes.) (Assist.)	$3,888.30

Item No.	Description	Max Fee (excl. GST)
36611	Intestinal urinary reservoir, continent, formation of (including associated small bowel resection and anastomosis), including formation of non-return valves and implantation of one or both ureters into reservoir, performed by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	$6,132.90
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)	$1,451.10
36615	Ureterolysis, unilateral, with or without repositioning of the ureter, for obstruction of the ureter, if: (a) the obstruction: (i) is evident either radiologically or by proximal ureteric dilatation at operation; and (ii) is secondary to retroperitoneal fibrosis; and (b) there is biopsy proven fibrosis, endometriosis or cancer at the site of the obstruction at time of surgery (Anaes.) (Assist.)	$1,658.90
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.)	$1,521.80
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.)	$1,109.20
36624	Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (H) (Anaes.) (Assist.)	$1,249.80
36627	Nephroscopy, percutaneous, with or without any one or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639 or 36645 applies (Anaes.)	$1,647.30
36633	Nephroscopy, percutaneous, with incision of any one or more of renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, other than a service associated with a service to which item 36627, 36639 or 36645 applies (H) (Anaes.) (Assist.)	$1,664.10
36636	Nephroscopy, percutaneous, with incision of any one or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639 or 36645 applies (Anaes.) (Assist.)	$946.30
36639	Nephroscopy, percutaneous, with destruction and extraction of one or two stones using ultrasound or electrohydraulic shock waves or lasers, other than a service to which item 36645 applies (Anaes.)	$1,859.00
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3cm in any dimension, or for 3 or more stones (Anaes.) (Assist.)	$2,543.60
36649	Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.)	$639.10
36650	Nephrostomy tube, removal of, using interventional radiology techniques, but not including imaging, if the ureter has been stented with a double J ureteric stent and that stent is left in place (Anaes.)	$334.10
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.)	$1,547.50
36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Anaes.) (Assist.)	$1,875.90
36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.)	$2,534.30
36663	Both: (a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placement of sacral nerve lead or leads; and (b) intra operative test stimulation, to manage: (i) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (ii) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (H) (Anaes.)	$1,566.60
36664	Both: (a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and (b) intra operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: (i) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (ii) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment; other than a service to which item 36663 applies (H) (Anaes.)	$1,389.50
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	$293.60
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of: (a) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (b) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (H) (Anaes.)	$796.20
36667	Sacral nerve lead or leads, removal of, if the lead was inserted to manage: (a) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (b) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (Anaes.)	$366.20

Item No.	Description	Max Fee (excl. GST)
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: (a) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (b) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (Anaes.)	$366.20
36671	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if: (a) the patient has been diagnosed with idiopathic overactive bladder; and (b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti cholinergic agents); and (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and (d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimulation; and (e) the patient is willing and able to comply with the treatment protocol; and (f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. For each patient applicable only once, unless the patient achieves at least a 50% reduction in overactive bladder symptoms from baseline at any time during the 3 month treatment period. Not applicable for a service associated with a service to which item 36672 or 36673 applies	$435.80
36672	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable for a service associated with a service to which item 36671 or 36673 applies	$435.80
36673	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and to the tapering treatment protocol, and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the maintenance treatment protocol comprises no more than 12 sessions, delivered over a 12 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable for service associated with a service to which item 36671 or 36672 applies	$435.80
36800	Bladder, catheterisation of, where no other procedure is performed (Anaes.)	$65.60
36803	Ureteroscopy, of one ureter, with or without any one or more of cystoscopy, ureteric meatotomy, or ureteric dilatation, other than a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824 or 36848 applies (H) (Anaes.) (Assist.)	$1,107.00
36806	Ureteroscopy, of one ureter: (a) with or without one or more of the following: (i) cystoscopy; (ii) endoscopic incision of pelviureteric junction or ureteric stricture; (iii) ureteric meatotomy; (iv) ureteric dilatation; and (b) with either or both of the following: (i) extraction of stone from the ureter; (ii) biopsy or diathermy of the ureter; other than: (c) a service associated with a service to which item 36803 or 36812 applies; or (d) a service associated with a service, performed on the same ureter, to which item 36809, 36824 or 36848 applies (Anaes.) (Assist.)	$1,543.50
36809	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824 or 36848 applies to a procedure performed on the same ureter (Anaes.) (Assist.)	$1,976.30
36811	Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other than a service associated with a service to which item 37203, 37207 or 37230 applies (H) (Anaes.)	$769.10
36812	Either or both of cystoscopy and urethroscopy, with or without urethral dilatation, other than a service associated with any other urological endoscopic procedure on the lower urinary tract (Anaes.)	$395.70
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.)	$565.80
36818	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluoroscopic imaging of the upper urinary tract, other than a service associated with a service to which item 36824 or 36830 applies (H) (Anaes.)	$656.00
36821	Cystoscopy with one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis, unilateral (H) (Anaes.) (Assist.)	$769.30
36822	Cystoscopy, with ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821 or 36830 applies (H) (Anaes.) (Assist.)	$1,011.00

Item No.	Description	Max Fee (excl. GST)
36823	Cystoscopy, with removal of ureteric stent and ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including either or both of the following: (i) ureteric dilatation; (ii) insertion of ureteric stent of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821, 36830 or 36833 applies (H) (Anaes.) (Assist.)	$1,162.40
36824	Cystoscopy with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 applies (H) (Anaes.)	$507.70
36827	Cystoscopy, with controlled hydro dilatation of the bladder, other than a service associated with a service to which item 37011 or 37245 applies (H) (Anaes.)	$551.00
36830	Cystoscopy, with ureteric meatotomy (Anaes.)	$483.00
36833	Cystoscopy with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.)	$617.50
36836	Cystoscopy with biopsy of bladder, other than a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203 or 37215 applies (Anaes.)	$545.10
36840	Cystoscopy, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, for: (a) a tumour or lesion in only one quadrant of the bladder; or (b) a solitary tumour of not more than 2cm in diameter; other than a service associated with a service to which item 36845 applies (H) (Anaes.)	$768.80
36842	Cystoscopy, with lavage of blood clots from bladder, including any associated cautery of prostate or bladder, other than a service associated with a service to which any of items 36812, 36827 to 36863 and 37203 apply (H) (Anaes.)	$777.80
36845	Cystoscopy, with diathermy, resection or visual laser destruction of: (a) multiple tumours in 2 or more quadrants of the bladder; or (b) a solitary bladder tumour of more than 2cm in diameter (H) (Anaes.)	$1,544.40
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.)	$545.80
36851	Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.)	$551.00
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.)	$1,107.20
36860	Endoscopic examination of intestinal conduit or reservoir (H) (Anaes.)	$373.00
36863	Litholapaxy, with or without cystoscopy (Anaes.)	$1,040.30
37000	BLADDER, partial excision of (Anaes.) (Assist.)	$1,742.30
37004	BLADDER, repair of rupture (Anaes.) (Assist.)	$1,458.40
37008	Open cystostomy or cystotomy, suprapubic, other than: (a) a service to which item 37011 applies; or (b) a service associated with a service to which item 37245 applies; or (c) another open bladder procedure (H) (Anaes.) (Assist.)	$989.60
37011	Suprapubic stab cystotomy, other than a service associated with a service to which item 36827 applies (Anaes.)	$219.20
37014	BLADDER, total excision of (Anaes.) (Assist.)	$2,488.10
37015	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.)	$2,802.80
37016	Cystectomy, including prostatectomy and pelvic lymph node dissection, other than a service associated with a service to which items 37000, 37014, 37015, 37209, 35551 or 36502 applies (Anaes.) (Assist.)	$4,370.30
37018	Cystectomy, including prostatectomy and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which items 37000, 37014, 37015, 37016, 37209, 35551 or 36502 applies (Anaes.) (Assist.)	$6,555.80
37019	Cystectomy, including anterior exenteration and pelvic lymph node dissection, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502, and 35653 to 35756 apply (Anaes.) (Assist.)	$4,365.50
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.)	$1,761.40
37021	Cystectomy, including anterior exenteration and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (Anaes.) (Assist.)	$6,548.30
37023	Vesical fistula, cutaneous, operation for (Anaes.)	$986.70
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.)	$975.00
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.)	$2,063.90
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)	$1,644.30
37039	Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (Anaes.) (Assist.)	$1,477.60

Item No.	Description	Max Fee (excl. GST)
37040	Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, other than a service associated with a service to which item 37042 applies (H) (Anaes.) (Assist.)	$2,062.90
37041	BLADDER ASPIRATION by needle	$111.00
37042	Bladder stress incontinence sling procedure for, using autologous fascial sling, including harvesting of sling, other than a service associated with a service to which item 35599 applies (H) (Anaes.) (Assist.)	$2,170.20
37044	Bladder stress incontinence, suprapubic operation for (such as Burch colposuspension), open or laparoscopic route, using native tissue without graft, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, not being a service associated with a service to which item 35599 or 36812 applies (H) (Anaes.) (Assist.)	$1,831.70
37045	Continent catheterisation bladder stomas (eg. mitrofanoff), formation of (Anaes.) (Assist.)	$3,413.70
37046	Suprapubic or perineal procedure for excision of graft material, either singly or in multiple pieces, for a symptomatic patient with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), if not more than one service to which this item applies has been provided to the patient by the same practitioner in the preceding 12 months (Anaes.) (Assist.)	$1,516.70
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.)	$3,741.90
37048	Bladder neck closure for the management of urinary incontinence (Anaes.) (Assist.)	$2,025.40
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.)	$1,664.10
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.)	$2,006.00
37200	Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	$2,417.60
37201	Prostate, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854, 37203, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	$1,851.70
37203	Prostatectomy, transurethral resection using cautery, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	$2,336.80
37207	Prostate, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37203, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	$2,513.50
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.)	$1,145.10
37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.)	$3,075.50
37210	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated) with or without bladder neck reconstruction, other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$3,779.30
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) with or without bladder neck reconstruction; and (b) with pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$4,592.90
37213	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$5,235.20
37214	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction and pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$6,359.00
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (H) (Anaes.)	$991.00
37216	Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.)	$307.80
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)	$317.80
37218	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.)	$328.20

Item No.	Description	Max Fee (excl. GST)
37219	Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.)	$761.40
37220	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by a urologist at an approved site in association with a radiation oncologist; and (c) being a service associated with: (i) services to which items 15966 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies (H) (Anaes.)	$2,521.50
37221	Prostatic abscess, endoscopic drainage of (Anaes.)	$1,096.30
37223	Prostatic coil, insertion of, under ultrasound control (Anaes.)	$464.40
37224	Prostate, diathermy or cauterisation, other than a service associated with a service to which item 37201, 37203, 37207, 37208 or 37215 applies (H) (Anaes.)	$722.30
37226	Prostate or prostatic bed, needle biopsy of, using prostatic magnetic resonance imaging techniques and obtaining 1 or more prostatic specimens. (Anaes.)	$606.10
37227	Prostate, transperineal insertion of catheters for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy, if performed at an approved site, and being a service associated with a service to which item 15966 applies (H)	$2,292.10
37245	Prostate, endoscopic enucleation of, for the treatment of benign prostatic hyperplasia: (a) with morcellation, including mechanical morcellation or by an endoscopic technique; and (b) with or without cystoscopy; and (c) with or without urethroscopy; and other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37203, 37207, 37208, 37303, 37321 or 37324 applies (H) (Anaes.)	$2,860.80
37300	Urethral sounds, passage of, as an independent procedure (Anaes.)	$111.10
37303	Urethral stricture, dilatation of (Anaes.)	$175.70
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.)	$1,549.50
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.)	$2,209.10
37318	Urethroscopy, with or without cystoscopy, with one or more of biopsy, diathermy, visual laser destruction of urethral calculi or removal of foreign body or calculi (H) (Anaes.)	$656.90
37321	Urethral meatotomy, external (Anaes.)	$223.00
37324	Urethrotomy or urethrostomy, internal or external (Anaes.) (Assist.)	$545.10
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.)	$767.00
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.)	$1,540.50
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.)	$1,306.80
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.)	$1,664.10
37338	Urethral synthetic male sling system, division or removal of, for urethral obstruction, sling erosion, pain or infection, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.)	$2,062.90
37339	Periurethral or transurethral injection of urethral bulking agents for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.)	$571.40
37340	Urethral synthetic sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service associated with a service to which item 37341 or 37344 applies (Anaes.) (Assist.)	$1,161.20
37341	Urethral sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, suprapubic, combined suprapubic and vaginal or combined suprapubic and perineal approach, other than a service associated with a service to which item 37340 or 37344 applies (Anaes.) (Assist.)	$2,161.40
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.)	$1,979.10
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.)	$3,302.00
37344	Urethral autologous fascial sling (or other biological sling), division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service to which 37340 or 37341 applies (Anaes.) (Assist.)	$1,996.40
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.)	$1,650.20

Item No.	Description	Max Fee (excl. GST)
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.)	$1,650.20
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$618.60
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.)	$773.20
37369	Urethra, excision of prolapse of (Anaes.)	$417.50
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.)	$1,281.10
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.)	$2,746.50
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)	$1,759.90
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)	$2,746.50
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.)	$767.40
37388	Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume	$214.50
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.)	$2,194.00
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.)	$547.90
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)	$1,736.50
37402	PENIS, partial amputation of (Anaes.) (Assist.)	$1,096.30
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.)	$2,198.40
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)	$1,096.30
37411	Penis, repair of avulsion (H) (Anaes.) (Assist.)	$2,165.00
37415	Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36 month period	$104.10
37417	Penis, correction of chordee by plication techniques including Nesbit s corporoplasty (Anaes.) (Assist.)	$1,315.60
37418	Penis, correction of chordee with incision or excision of fibrous plaque or plaques, with or without mobilisation of one or both of the neuro-vascular bundle and urethra (H) (Anaes.) (Assist.)	$1,759.90
37423	Penis, lengthening by translocation of corpora, in conjunction with partial penectomy or penile epispadias secondary repair, either as primary or secondary procedures (Anaes.) (Assist.)	$2,198.40
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)	$2,308.00
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)	$767.40
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.)	$2,192.00
37435	Penis, frenuloplasty as an independent procedure (Anaes.)	$219.20
37438	Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.)	$660.70
37601	Spermatocele or epididymal cyst, excision of, 1 or more of, on 1 side (Anaes.)	$617.40
37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral or bilateral, other than a service associated with sperm harvesting for IVF (H) (Anaes.)	$652.10
37605	Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes of intracytoplasmic sperm injection, for male factor infertility, excluding a service to which item 13218 applies. (Anaes.)	$886.20
37606	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with or without biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a hospital, other than a service to which item 13218 or 37604 applies (H) (Anaes.)	$1,316.30
37607	Bilateral retroperitoneal lymph node dissection, for testicular tumour, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2,518.90
37610	Bilateral retroperitoneal lymph node dissection, for testicular tumour, following previous similar retroperitoneal dissection, retroperitoneal radiation therapy or chemotherapy, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3,823.70
37613	Epididymectomy (H) (Anaes.)	$657.80
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.)	$2,151.00
37619	Vasovasostomy or vasoepididymostomy, unilateral, other than a service associated with sperm harvesting for IVF (H) (Anaes.) (Assist.)	$1,233.70

Item No.	Description	Max Fee (excl. GST)
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.)	$550.80
37800	PATENT URACHUS, excision of, on a patient 10 years of age or over. (Anaes.) (Assist.)	$1,164.90
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies, on a patient 10 years of age or over. (Anaes.) (Assist.)	$1,241.80
37804	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a patient under 10 years of age (Anaes.) (Assist.)	$1,565.90
37806	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	$1,356.90
37807	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient under 10 years of age (H) (Anaes.) (Assist.)	$1,809.50
37809	UNDESCENDED TESTIS, revision orchidopexy for, on a patient 10 years of age or over. (Anaes.) (Assist.)	$1,422.70
37810	UNDESCENDED TESTIS, revision orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.)	$1,809.50
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803, 37806 and 37809 applies, on a patient 10 years of age or over. (Anaes.) (Assist.)	$1,320.70
37813	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a patient under 10 years of age (Anaes.) (Assist.)	$1,670.50
37815	HYPOSPADIAS, examination under anaesthesia with erection test on a patient 10 years of age or over. (Anaes.)	$222.10
37816	HYPOSPADIAS, examination under anaesthesia with erection test, on a patient under 10 years of age (Anaes.)	$278.80
37818	Hypospadias, glanuloplasty incorporating meatal advancement, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	$1,168.80
37819	Hypospadias, glanuloplasty incorporating meatal advancement, on a patient under 10 years of age (H) (Anaes.) (Assist.)	$1,476.80
37821	HYPOSPADIAS, distal, 1 stage repair, on a patient 10 years of age or over. (Anaes.) (Assist.)	$1,981.90
37822	HYPOSPADIAS, distal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.)	$2,503.10
37824	HYPOSPADIAS, proximal, 1 stage repair, on a patient 10 years of age or over (Anaes.) (Assist.)	$2,746.50
37825	HYPOSPADIAS, proximal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.)	$3,480.10
37827	HYPOSPADIAS, staged repair, first stage, on a patient 10 years of age or over (Anaes.) (Assist.)	$1,243.00
37828	HYPOSPADIAS, staged repair, first stage, on a patient under 10 years of age (Anaes.) (Assist.)	$1,603.40
37830	Hypospadias, staged repair, second stage, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	$1,610.60
37831	Hypospadias, staged repair, second stage, on a patient under 10 years of age (H) (Anaes.) (Assist.)	$2,077.60
37833	Hypospadias, repair of urethral fistula, on a patient 10 years of age or over (Anaes.) (Assist.)	$771.50
37834	Hypospadias, repair of urethral fistula, on a patient under 10 years of age (Anaes.) (Assist.)	$991.30
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.)	$1,619.30
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.)	$1,834.90
37842	Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.)	$3,642.70
37845	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (Anaes.) (Assist.)	$1,619.30
37848	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty with endoscopy and vaginoplasty (Anaes.) (Assist.)	$2,914.30
37851	Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.)	$2,159.10
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (Anaes.)	$875.50

Item No.	Description	Max Fee (excl. GST)
	Cardio-thoracic	
38200	Right heart catheterisation with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurement by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38254 or 38368 applies (H) (Anaes.)	$1,001.60
38203	Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38206, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (H) (Anaes.)	$1,197.40
38206	Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38203, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (H) (Anaes.)	$1,448.20
38209	Cardiac electrophysiological study up to and including 3 catheter investigation of any one or more of syncope, atrio ventricular conduction, sinus node function or simple ventricular tachycardia studies, other than a service associated with a service to which item 38212 or 38213 applies (H) (Anaes.)	$1,920.40
38212	Cardiac electrophysiological study for: (a) the investigation of supraventricular tachycardia involving 4 or more catheters; or (b) complex tachycardia inductions; or (c) multiple catheter mapping; or (d) acute intravenous anti arrhythmic drug testing with pre and post drug inductions; or (e) catheter ablation to intentionally induce complete atrioventricular block; or (f) intraoperative mapping; other than a service associated with a service to which item 38209 or 38213 applies (H) (Anaes.)	$3,285.90
38213	Cardiac electrophysiological study, performed either: (a) during insertion of implantable defibrillator; or (b) for defibrillation threshold testing at a different time to implantation; other than a service associated with a service to which item 38209 or 38212 applies (H) (Anaes.)	$911.90
38241	Use of a coronary pressure wire, if the service is: (a) performed during selective coronary angiography, percutaneous angioplasty or transluminal insertion of one or more stents; and (b) to measure fractional flow reserve, non-hyperaemic pressure ratios or coronary flow reserve in intermediate coronary artery or graft lesions (stenosis of 50 to 70%); and (c) to determine whether revascularisation is appropriate, if previous functional imaging: (i) has not been performed; or (ii) has been performed but the results are inconclusive or do not apply to the vessel being interrogated; and (d) performed on one or more coronary vascular territories (H) (Anaes.)	$1,117.90
38244	Note: (acute coronary syndrome) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Selective coronary angiography: (a) for a patient who is eligible for the service under Clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into native coronary arteries; and (c) with or without left heart catheterisation, left ventriculography or aortography; and (d) including all associated imaging; other than a service associated with a service to which 38200, 38203, 38206, 38247, 38248, 38249, 38251 or 38252 applies (H) (Anaes.)	$2,011.50
38247	Note: (acute coronary syndrome - graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Selective coronary and graft angiography: (a) for a patient who is eligible for the service under Clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (c) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38248, 38249, 38251 or 38252 applies (H) (Anaes.)	$3,222.50
38248	Note: (stable coronary syndrome) the service only applies if the patient meets the requirements of the descriptor and the of Note: TR.8.3 and TR.8.5 Selective coronary angiography: (a) for a patient who is eligible for the service under Clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38249, 38251 or 38252 applies applicable each 3 months (H) (Anaes.)	$2,011.50
38249	Note: (stable coronary syndrome - graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 and TR.8.5 Selective coronary and graft angiography: (a) for a patient who is eligible for the service under Clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38251 or 38252 applies applicable once each 3 months (H) (Anaes.)	$3,222.50

Item No.	Description	Max Fee (excl. GST)
38251	Note: (pre-operative assessment) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.5 Selective coronary angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38252 applies applicable once each 12 months (H) (Anaes.)	$2,011.50
38252	Note: (pre-operative assessment - graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.5 Selective coronary and graft angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38251 applies applicable once each 12 months (H) (Anaes.)	$3,222.50
38254	Right heart catheterisation: (a) performed at the same time as a service to which item 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313 or 38314 applies; and (b) including any of the following (if performed): (i) fluoroscopy; (ii) oximetry; (iii) dye dilution curves; (iv) cardiac output measurement; (v) shunt detection; (vi) exercise stress test (H) (Anaes.)	$1,013.30
38256	Temporary transvenous pacemaking electrode, insertion of (H) (Anaes.)	$609.90
38270	Balloon valvuloplasty or isolated atrial septostomy, including cardiac catheterisations before and after balloon dilatation (H) (Anaes.) (Assist.)	$2,058.30
38272	Atrial septal defect or patent foramen closure: (a) for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism; and (b) using a septal occluder or similar device, by transcatheter approach; and (c) including right or left heart catheterisation (or both); other than a service associated with a service to which item 38200, 38203, 38206 or 38254 applies (H) (Anaes.) (Assist.)	$2,035.50
38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.)	$2,157.10
38274	Ventricular septal defect, transcatheter closure of, with cardiac catheterisation, excluding imaging (H) (Anaes.) (Assist.)	$1,371.90
38275	Myocardial biopsy, by cardiac catheterisation (H) (Anaes.)	$712.50
38276	Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non valvular atrial fibrillation, if: (a) the patient is at increased risk of thromboembolism demonstrated by: (i) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non central nervous system systemic embolism; or (ii) at least 2 of the following risk factors: (A) an age of 65 years or more; (B) hypertension; (C) diabetes mellitus; (D) heart failure or left ventricular ejection fraction of 35% or less (or both); (E) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque); and (b) the patient has an absolute and permanent contraindication to oral anticoagulation (confirmed by written documentation that is provided by a medical practitioner, independent of the practitioner rendering the service); and (c) the service is not associated with a service to which item 38200, 38203, 38206 or 38254 applies (H) (Anaes.) (Assist.)	$2,032.60
38285	Insertion of implantable ECG loop recorder, by a specialist or consultant physician, for the diagnosis of a primary disorder, including initial programming and testing, if: (a) the patient has recurrent unexplained syncope and does not have a structural heart defect associated with a high risk of sudden cardiac death; and (b) a diagnosis has not been achieved through all other available cardiac investigations; and (c) a neurogenic cause is not suspected (Anaes.)	$385.50
38286	Removal of implantable ECG loop recorder (Anaes.)	$318.60
38287	Ablation of arrhythmia circuit or focus or isolation procedure involving one atrial chamber (H) (Anaes.) (Assist.)	$5,024.10
38288	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if: (a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and (b) the bases of the diagnosis included the following: (i) the medical history of the patient; (ii) physical examination; (iii) brain and carotid imaging; (iv) cardiac imaging; (v) surface ECG testing including 24 hour Holter monitoring; and (c) atrial fibrillation is suspected; and (d) the patient: (i) does not have a permanent indication for oral anticoagulants; or (ii) does not have a permanent oral anticoagulants contraindication; including initial programming and testing (Anaes.)	$429.80

Item No.	Description	Max Fee (excl. GST)
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)	$6,394.20
38293	Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (H) (Anaes.) (Assist.)	$6,866.50
38307	Note: (acute coronary syndrome - 1 coronary territory with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$4,032.90
38308	Note: (acute coronary syndrome - 2 coronary territories with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$4,639.80
38309	Percutaneous transluminal rotational atherectomy of one or more coronary arteries, including all associated imaging, if: (a) the target stenosis within at least one coronary artery is heavily calcified and balloon angioplasty with or without stenting is not feasible without rotational artherectomy; and (b) the service is performed in conjunction with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable only once on each occasion the service is performed (H) (Anaes.) (Assist.)	$2,376.10
38310	Note: (acute coronary syndrome - 3 coronary territories with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$5,246.90
38311	Note: (stable multi-vessel disease - 1 coronary territory with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under Clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$4,032.90
38313	Note: (stable multi-vessel disease - 2 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under Clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$4,639.80
38314	Note: (stable multi-vessel disease - 3 coronary territory with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17C; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38316, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$5,246.90

Item No.	Description	Max Fee (excl. GST)
38316	Note: (acute coronary syndrome - 1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38317, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$3,605.10
38317	Note: (acute coronary syndrome - 2 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38319, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$4,566.70
38319	Note: (acute coronary syndrome - 3 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38320, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$5,173.80
38320	Note: (stable multi-vessel disease - 1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under Clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38322 or 38323 applies (H) (Anaes.) (Assist.)	$3,605.10
38322	Note: (stable multi-vessel disease - 2 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under Clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38323 applies (H) (Anaes.) (Assist.)	$4,566.70
38323	Note: (stable multi-vessel disease - 3 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under Clause 5.10.17C; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38322 applies (H) (Anaes.) (Assist.)	$5,173.80
38325	Use of intravascular ultrasound (IVUS) during transluminal insertion of stents, to optimise procedural strategy, appropriate stent size and assessment of stent apposition, for a patient documented with: (a) one or more left main coronary artery lesions; or (b) one or more lesions at least 28mm in length in other locations; if performed in association with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable once per episode of care (for one or more lesions) (H) (Anaes.)	$880.60
38326	Use of optical coherence tomography (OCT) during transluminal insertion of stents, to optimise procedural strategy, appropriate stent size and assessment of stent apposition, if: (a) the patient is documented with: (i) one or more lesions located at a bifurcation; and (ii) a planned side branch at least 2.5mm in diameter by angiographic visual estimation; or (b) the patient is documented with stent thrombosis; or (c) both: (i) the patient is documented with one or more lesions at least 28mm in length; and (ii) either of the following apply: (A) a service to which this item applies is not performed in association with a service to which item 38325 applies because of paragraph (b) of that item; (B) a service to which this item applies is not performed, in relation to a lesion, in association with a service to which item 38325 applies because of paragraph (a) of that item, performed in relation to the same lesion; if performed in association with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable once per episode of care (for one or more lesions) (H)	$808.70

Item No.	Description	Max Fee (excl. GST)
38350	Single chamber permanent transvenous electrode, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$1,480.50
38353	Permanent cardiac pacemaker, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$577.30
38356	Dual chamber permanent transvenous electrodes, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$1,934.00
38358	Extraction of one or more chronically implanted transvenous pacing or defibrillator leads, by percutaneous method, with locking stylets and snares, with extraction sheaths (if any), if: (a) the leads have been in place for more than 6 months and require removal; and (b) the service is performed: (i) in association with a service to which item 61109 or 60509 applies; and (ii) by a specialist or consultant physician who has undertaken the training to perform the service; and (iii) in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist a cardiothoracic surgeon is in attendance during the service (H) (Anaes.) (Assist.)	$6,985.20
38359	Pericardium, paracentesis of (excluding aftercare) (Anaes.)	$319.40
38362	Intra-aortic balloon pump, percutaneous insertion of (H) (Anaes.)	$919.20
38365	Insertion, removal or replacement of permanent cardiac synchronisation device, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following: (i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 38212 applies (H) (Anaes.) (Assist.)	$613.60
38368	Insertion, removal or replacement of permanent transvenous left ventricular electrode, through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venograms, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following: (i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 35200, 38200 or 38212 applies (H) (Anaes.) (Assist.)	$2,911.10
38372	Leadless permanent cardiac pacemaker, single-chamber ventricular, percutaneous insertion of, for the treatment of bradycardia, including cardiac electrophysiological services (other than a service associated with a service to which item 38350 applies) (H) (Anaes.)	$1,437.30
38373	Leadless permanent cardiac pacemaker, single chamber ventricular, percutaneous retrieval and replacement of, including cardiac electrophysiological services, during the same percutaneous procedure, if: (a) the service is performed by a specialist or consultant physician who has undertaken training to perform the service; and (b) if the service is performed at least 4 weeks after the pacemaker was inserted the service is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist at least 4 weeks after the pacemaker was inserted a cardiothoracic surgeon is in attendance during the service; other than a service associated with a service to which item 38350 applies (H) (Anaes.)	$1,437.30
38374	Leadless permanent cardiac pacemaker, single chamber ventricular, percutaneous retrieval of, if: (a) the service is performed by a specialist or consultant physician who has undertaken training to perform the service; and (b) if the service is performed at least 4 weeks after the pacemaker was inserted the service is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist at least 4 weeks after the pacemaker was inserted a cardiothoracic surgeon is in attendance during the service (H) (Anaes.)	$1,437.30
38375	Leadless permanent cardiac pacemaker, single-chamber ventricular, explantation of, by open surgical approach (H) (Anaes.) (Assist.)	$5,378.40
38376	Percutaneous insertion of an intravascular microaxial ventricular assist device, into the left ventricle only, by arteriotomy, including all associated intraoperative imaging performed by the same practitioner, if: (a) the patient has deteriorating symptoms of cardiogenic shock (with no evidence of significant anoxic neurological injury) that are not controlled by optimal medical therapy; or (b) the patient: (i) is on veno arterial extra corporeal membrane oxygenation, for deteriorating symptoms of cardiogenic shock (with no evidence of significant anoxic neurological injury) that are not controlled by optimal medical therapy; and (ii) due to the effects of established veno arterial extra corporeal membrane oxygenation, requires unloading of the left ventricle (H) (Anaes.)	$1,077.00
38416	Endoscopic ultrasound guided fine needle aspiration biopsy or biopsies (endoscopy with ultrasound imaging) to obtain one or more specimens from either or both of the following: (a) mediastinal masses; (b) locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, or item 38417 or 55054, applies (H) (Anaes.)	$1,286.80

Item No.	Description	Max Fee (excl. GST)
38417	Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, item 38416, 38420 or 38423, or an item in Subgroup 15 of Group I3, applies (H) (Anaes.)	$1,286.80
38419	Bronchoscopy, as an independent procedure (H) (Anaes.)	$423.20
38420	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (H) (Anaes.)	$557.80
38422	Bronchus, removal of foreign body in (Anaes.) (Assist.)	$829.20
38423	Fibreoptic bronchoscopy with one or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (H) (Anaes.) (Assist.)	$609.00
38425	Endoscopic resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures, other than a service associated with a service to which another item in Group T8 applies (H) (Anaes.) (Assist.)	$1,441.90
38426	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.)	$1,081.50
38428	Bronchoscopy with treatment of tracheal stricture (H) (Anaes.)	$545.10
38429	Tracheal excision and repair of, without cardiopulmonary bypass (H) (Anaes.) (Assist.)	$3,458.80
38431	Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.)	$4,678.10
38461	TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more tissue approximation implants, including intra operative diagnostic imaging, if: (a) the patient has each of the following risk factors: (i) moderate to severe, or severe, symptomatic degenerative (primary) mitral valve regurgitation (grade 3+ or 4+); (ii) left ventricular ejection fraction of 20% or more; (iii) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV); and (b) as a result of a TMVr suitability case conference, the patient has been: (i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and (ii) recommended as being suitable for the service; and (c) the service is performed: (i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and (ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and (iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and (d) a service to which this item, or item 38463, applies has not been provided to the patient in the previous 5 years (H) (Anaes.) (Assist.)	$3,258.20
38463	TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more Mitraclips , including intra operative diagnostic imaging, if: (a) the patient has each of the following risk factors: (i) moderate to severe, or severe, symptomatic functional (secondary) mitral valve regurgitation (grade 3+ or 4+); (ii) left ventricular ejection fraction of 20% to 50%; (iii) left ventricular end systolic diameter of not more than 70mm; (iv) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV) that persist despite maximally tolerated guideline directed medical therapy; and (b) as a result of a TMVr suitability case conference, the patient has been: (i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and (ii) recommended as being suitable for the service; and (c) the service is performed: (i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and (ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and (iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and (d) a service to which this item, or item 38461, applies has not been provided to the patient in the previous 5 years (H) (Anaes.) (Assist.)	$3,258.20
38467	Insertion, removal or replacement of permanent myocardial electrode, by open surgical approach, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$2,180.30
38471	Insertion of implantable defibrillator, including insertion of patches for the insertion of one or more transvenous endocardial leads, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist.)	$2,394.80
38472	Insertion, replacement or removal of implantable defibrillator generator, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist.)	$654.90

Item No.	Description	Max Fee (excl. GST)
38474	Repair, augmentation or replacement of branch pulmonary arteries left or right (or both), with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,934.70
38477	Valve annuloplasty with insertion of ring, other than: (a) a service to which item 38516 or 38517 applies; or (b) a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,771.20
38484	Aortic or pulmonary valve replacement with bioprosthesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,617.90
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.)	$1,942.60
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)	$4,029.50
38490	Reconstruction and re-implantation of sub-valvular structures, if performed in conjunction with a service to which item 38499 applies (H) (Anaes.) (Assist.)	$1,317.50
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.)	$4,658.60
38495	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at high risk for surgery; and (b) the service: (i) is performed by a TAVI Practitioner in a TAVI Hospital; and (ii) includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and (iii) includes valvuloplasty, if required; not being a service which has been rendered within 5 years of a service to which this item or item 38514 or 38522 applies (H) (Anaes.) (Assist.)	$3,190.80
38499	Mitral or tricuspid valve replacement with bioprothesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,617.90
38502	Coronary artery bypass, including cardiopulmonary bypass, with or without retrograde cardioplegia, with or without vein grafts, and including at least one of the following: (a) harvesting of left internal mammary artery and vein graft material; (b) harvesting of left internal mammary artery; (c) harvesting of vein graft material; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,359.90
38508	Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,848.10
38509	Repair of ischaemic ventricular septal rupture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,385.50
38510	Artery harvesting (other than of the left internal mammary), for coronary artery bypass, if: (a) more than one arterial graft is required; and (b) the service is performed in conjunction with coronary artery bypass surgery performed by any medical practitioner (H) (Anaes.) (Assist.)	$1,419.50
38511	Coronary artery bypass, with the aid of tissue stabilisers, if: (a) the service is performed without cardiopulmonary bypass; and (b) the service is performed in conjunction with a service to which item 38502 applies Applicable only once in conjunction with each service to which item 38502 applies (H) (Anaes.) (Assist.)	$1,364.90
38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,987.90
38513	Creation of Y graft, T graft and graft to graft extensions, with micro arterial or micro venous anastomosis using microsurgical techniques, if: (a) the service is for one or more anastomoses; and (b) the service is performed in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.)	$2,275.00
38514	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at intermediate risk for surgery; and (b) the service: is performed by a TAVI Practitioner in a TAVI Hospital; and includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and includes valvuloplasty, if required; and is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and if performed by an interventional cardiologist, a cardiothoracic surgeon is in attendance during the service; not being a service which has been rendered within 5 years of a service to which this item or item 38495 or 38522 applies (H) (Anaes.) (Assist.)	$3,040.90
38515	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,380.80

Item No.	Description	Max Fee (excl. GST)
38516	Simple valve repair: (a) with or without annuloplasty; and (b) including quadrangular resection, cleft closure or alfieri; and (c) including retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,035.10
38517	Complex valve repair: (a) with or without annuloplasty; and (b) including retrograde cardioplegia (if performed); and (c) including one of the following: (i) neochords; (ii) chordal transfer; (iii) patch augmentation; (iv) multiple leaflets; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$7,349.70
38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,468.30
38519	Valve explant of a previous prosthesis, if performed during open cardiac surgery, not being a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$2,404.90
38522	TAVI, for the treatment of symptomatic severe native calcific aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at low risk for surgery; and (b) the service: is performed by a TAVI Practitioner in a TAVI Hospital; and includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and includes valvuloplasty, if required; and is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and if performed by an interventional cardiologist, a cardiothoracic surgeon is in attendance during the service; not being a service which has been rendered within 5 years of a service to which this item or item 38495 or 38514 applies (H) (Anaes.) (Assist.)	$3,089.50
38523	Percutaneous transcatheter delivery of dual-filter cerebral embolic protection system during a TAVI procedure, for the reduction of postoperative embolic ischaemic strokes, if: the service is performed upon a TAVI Patient in a TAVI Hospital; and where the service is performed by the practitioner performing the TAVI procedure, the service includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient (H) (Anaes.) (Assist.)	$561.50
38550	Repair or replacement of ascending thoracic aorta: (a) including: (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including valve replacement or repair or implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,141.80
38553	Repair or replacement of ascending thoracic aorta: (a) including: (i) aortic valve replacement or repair; and (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,768.30
38554	Valve sparing aortic root surgery, with reimplantation of aortic valve and coronary arteries and replacement of the ascending aorta, including cardiopulmonary bypass, and including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$9,262.30
38555	Simple replacement or repair of aortic arch, performed in conjunction with a service to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) deep hypothermic circulatory arrest; and (b) peripheral cannulation for cardiopulmonary bypass; and (c) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,716.60
38556	Repair or replacement of ascending thoracic aorta, including: (a) aortic valve replacement or repair; and (b) implantation of coronary arteries; and (c) cardiopulmonary bypass; and (d) retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,972.80
38557	Complex replacement or repair of aortic arch, performed in conjunction with a service, performed by any medical practitioner, to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) debranching and reimplantation of head and neck vessels; and (b) deep hypothermic circulatory arrest; and (c) peripheral cannulation for cardiopulmonary bypass; and (d) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$9,366.50
38558	Aortic repair involving augmentation of hypoplastic or interrupted aortic arch, if: (a) the patient is a neonate; and (b) the service includes: (i) the use of antegrade cerebral perfusion or deep hypothermic circulatory arrest and associated myocardial preservation; and (ii) retrograde cardioplegia; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,1114.60
38568	Repair or replacement of descending thoracic aorta, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,157.90
38571	Repair or replacement of descending thoracic aorta, with shunt or cardiopulmonary bypass, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,880.90

Item No.	Description	Max Fee (excl. GST)
38572	Operative management of acute rupture or dissection, if the service: (a) is performed in conjunction with a service to which item 38550, 38553, 38554, 38555, 38556, 38557, 38558, 38568, 38571, 38706 or 38709 applies; and (b) is not associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,438.90
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$3,455.50
38603	Peripheral cannulation for cardiopulmonary bypass, excluding post-operative management, other than a service: (a) in which peripheral cannulation is used in preference to central cannulation for valve or coronary bypass procedures; or (b) associated with a service to which item 38555 or 38572 applies (H) (Anaes.) (Assist.)	$2,137.80
38609	Insertion of intra-aortic balloon pump, by arteriotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,141.50
38612	Removal of intra-aortic balloon pump, with closure of artery by direct suture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 338816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,257.40
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.)	$3,455.50
38616	Surgical insertion of an intravascular microaxial ventricular assist device, into the left ventricle only, by arteriotomy, including all associated intraoperative imaging performed by the same practitioner, if: (a) the patient has deteriorating symptoms of cardiogenic shock (with no evidence of significant anoxic neurological injury) that are not controlled by optimal medical therapy; or (b) the patient: (i) is on veno arterial extra corporeal membrane oxygenation, for deteriorating symptoms of cardiogenic shock (with no evidence of significant anoxic neurological injury) that are not controlled by optimal medical therapy; and (ii) due to the effects of established veno arterial extra corporeal membrane oxygenation, requires unloading of the left ventricle (H) (Anaes.)	$1,615.50
38618	Insertion of a left and right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.)	$4,302.60
38619	Surgical removal of a left sided intravascular microaxial ventricular assist device (H) (Anaes.)	$969.00
38620	Insertion of a durable left ventricular assist device capable of providing mechanical circulatory support for at least 6 months: (a) as destination therapy in the management of a patient who: (i) has refractory heart failure despite optimal medical management including device use where appropriate; and (ii) has an INTERMACS profile of 1, 2, 3 or 4; and (iii) is not expected to be a suitable candidate for cardiac transplantation; and (b) including all associated intraoperative imaging performed by the same practitioner; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies Applicable only once per lifetime (H) (Anaes.) (Assist.)	$2,680.70
38621	Left or right ventricular assist device, removal or replacement of, as an independent procedure, other than a service to which item 38619 applies, or a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38619, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,708.60
38624	Left and right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,929.40
38627	Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation, in patients supported by these devices, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,562.10
38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,252.10
38653	Open heart surgery, other than a service: (a) to which another item in this Group applies; or (b) associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,747.80

Item No.	Description	Max Fee (excl. GST)
38670	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,570.30
38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,150.30
38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,529.10
38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,372.30
38700	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$2,528.30
38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,341.90
38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,105.20
38709	Anastomosis or repair of aorta, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,815.30
38715	Main Pulmonary Artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$3,995.10
38718	Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,093.20
38721	Vena Cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$3,369.50
38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,177.00
38727	Anastomosis or repair of intrathoracic vessels, without cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$3,377.90
38730	Anastomosis or repair of intrathoracic vessels, with cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,815.30
38733	Systemic pulmonary or Cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$3,502.40
38736	Systemic pulmonary or Cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,998.30
38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,498.10
38742	Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,577.60
38745	Intra-atrial baffle, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,067.70
38748	Ventricular septectomy, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,083.30
38751	Ventricular septal defect, closure by direct suture or patch, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,098.30

Item No.	Description	Max Fee (excl. GST)
38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$6,257.20
38757	Extracardiac conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,083.30
38760	Extracardiac conduit, replacement of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,998.30
38764	Ventricular myectomy, for relief of right or left ventricular obstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$4,855.80
38766	Ventricular augmentation, right or left, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$5,076.20
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies	$91.90
38803	Thoracic cavity, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample	$173.40
38812	Percutaneous needle biopsy of lung (Anaes.)	$466.70
38815	Thoracoscopy, with or without division of pleural adhesions, with or without biopsy, including insertion of intercostal catheter where necessary, other than a service associated with: (a) a service to which item 18258, 18260 or 38828 applies; or (b) a service to which item 38816 applies that is performed on the same lung (H) (Anaes.) (Assist.)	$501.80
38816	Thoracotomy, exploratory, with or without biopsy, including insertion of an intercostal catheter where necessary, other than a service associated with: (a) a service to which item 18258, 18260 or 38828 applies; or (b) a service to which item 38815 applies that is performed on the same lung (H) (Anaes.) (Assist.)	$1,926.20
38817	Thoracotomy, thoracoscopy or sternotomy, by any procedure: (a) including any division of adhesions if the time taken to divide the adhesions exceeds 30 minutes; and (b) other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38818, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$3,028.00
38818	Thoracotomy, thoracoscopy or median sternotomy for post operative bleeding, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38817, 38828 or 45503 applies (H) (Anaes.) (Assist.)	$1,926.20
38820	Lung, wedge resection of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820, 38821 or 38828 applies (H) (Anaes.) (Assist.)	$2,305.70
38821	Lung, wedge resection of, 2 or more wedges, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820 or 38828 applies (H) (Anaes.) (Assist.)	$3,458.40
38822	Pneumonectomy, lobectomy, bilobectomy or segmentectomy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38823, 38824 or 38828 applies (H) (Anaes.) (Assist.)	$3,078.90
38823	Radical lobectomy, pneumonectomy, bilobectomy, segmentectomy or formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38824 or 38828 applies (H) (Anaes.) (Assist.)	$3,804.40
38824	Segmentectomy, lobectomy, bilobectomy or pneumonectomy, including resection of chest wall, diaphragm, pericardium, and formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38823 or 38828 applies (H) (Anaes.) (Assist.)	$4,755.30
38828	Intercostal drain, insertion of: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38829, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.)	$268.40
38829	Intercostal drain, insertion of, with pleurodesis: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38828, 38830, 38831, 38832, 38833 or 38834 applies (H) (Anaes.)	$330.70
38830	Empyema, radical operation for, involving resection of rib, other than a service associated with a service to which item 38828, 38829, 38831, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.)	$802.60
38831	Thoracoscopy or thoracotomy and drainage of paraneumonic effusion and empyema, exploratory, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.)	$2,889.30
38832	Thoracotomy or thoracoscopy, with pulmonary decortication, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38833 or 38834 applies (H) (Anaes.) (Assist.)	$3,078.90

Item No.	Description	Max Fee (excl. GST)
38833	Thoracotomy or thoracoscopy, with pleurectomy or pleurodesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38834 applies (H) (Anaes.) (Assist.)	$1,926.20
38834	Thoracotomy and radical extra pleural pneumonectomy or radical lung preserving decortication and pleurectomy for malignancy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38833 applies (H) (Anaes.) (Assist.)	$7,133.10
38837	Mediastinum, cervical exploration of, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	$729.70
38838	Thoracotomy or thoracoscopy or sternotomy, for removal of thymus or mediastinal tumour, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	$2,378.50
38839	Pericardium, subxiphoid open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38840 applies (H) (Anaes.) (Assist.)	$1,153.10
38840	Pericardium, transthoracic (thoracotomy or thoracoscopy) open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38839 applies (H) (Anaes.) (Assist.)	$1,721.60
38841	Pericardiectomy via sternotomy or thoracoscopy or anterolateral thoracotomy without cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	$3,078.90
38842	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	$4,307.40
38845	Sternal wire or wires, removal of, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.)	$553.50
38846	Pectus excavatum or pectus carinatum, repair or radical correction of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38847, 38848 or 38849 applies (H) (Anaes.) (Assist.)	$2,874.50
38847	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846, 38848 or 38849 applies (H) (Anaes.) (Assist.)	$1,532.20
38848	Pectus excavatum, repair of, with insertion of a concave bar, by any method, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.)	$2,299.60
38849	Pectus excavatum, removal of a concave bar, by any method, not being a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.)	$1,149.60
38850	Sternotomy wound, debridement of, not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38851 applies (H) (Anaes.)	$656.10
38851	Sternotomy wound, debridement of, involving curettage of infected bone, with or without removal of wires, but not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38850 applies (H) (Anaes.)	$713.20
38852	Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38853 applies (H) (Anaes.) (Assist.)	$1,925.40
38853	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and/or greater omentum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38852 applies (H) (Anaes.) (Assist.)	$3,018.50
38857	Chest wall resection, sternum and/or ribs without reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38858 applies (H) (Anaes.) (Assist.)	$3,648.00
38858	Chest wall resection, sternum and / or ribs with reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38857 applies (H) (Anaes.) (Assist.)	$4,755.30
38859	Plating of multiple ribs for flail segment, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	$1,926.20
38864	Intrathoracic operations on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than one of those organs, not being a service to which another item in this Group applies, other than a service associated with a service to which item 18258, 18260 or 38828 applies (H) (Anaes.) (Assist.)	$3,078.90

Item No.	Description	Max Fee (excl. GST)
	Neurosurgical	
39000	Lumbar puncture (Anaes.)	$181.30
39007	Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (H) (Anaes.)	$349.20
39013	Injection of one or more zygo-apophyseal or costo-transverse joints with one or more of contrast media, local anaesthetic or corticosteroid under image guidance (Anaes.)	$243.80
39014	Medial branch block of one or more primary posterior rami, injection of an anaesthetic agent under image guidance (Anaes.)	$265.20
39015	Intracranial parenchymal pressure monitoring device, insertion of including burr hole (excluding after care) (Anaes.)	$893.00
39018	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.)	$1,023.70
39100	Injection of primary branch of trigeminal nerve (ophthalmic, maxillary or mandibular branches) with alcohol, cortisone, phenol, or similar neurolytic substance, under image guidance (Anaes.)	$556.50
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (H) (Anaes.) (Assist.)	$1,447.30
39110	Left lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	$569.20
39111	Right lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	$569.20
39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$5,209.20
39116	Left thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	$632.40
39117	Right thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	$632.40
39118	Left cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	$775.70
39119	Right cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	$695.60
39121	Percutaneous cordotomy (H) (Anaes.) (Assist.)	$1,479.10
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)	$3,960.00
39125	Spinal catheter, insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.)	$691.70
39126	All of the following: (a) infusion pump, subcutaneous implantation or replacement of; (b) connection of the pump to a spinal catheter; (c) filling of reservoir with a therapeutic agent or agents;with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.)	$808.60
39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic pain, including cancer pain (H) (Anaes.)	$1,137.10
39128	All of the following: (a) infusion pump, subcutaneous implantation of; (b) spinal catheter, insertion of; (c) connection of pump to catheter; (d) filling of reservoir with a therapeutic agent or agents;with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.)	$1,567.50
39129	Peripheral lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain (H) (Anaes.) (Assist.)	$1,288.20
39130	Epidural lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.)	$1,599.00

Item No.	Description	Max Fee (excl. GST)
39131	Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending, for the management of chronic neuropathic pain or pain from refractory angina pectoris each day	$287.40
39133	Either: (a) subcutaneously implanted infusion pump, removal of; or (b) spinal catheter, removal or repositioning of;for the management of chronic pain, including cancer pain (H) (Anaes.)	$356.70
39134	Neurostimulator or receiver, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.)	$816.40
39135	Neurostimulator or receiver that was inserted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.)	$380.40
39136	Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.)	$356.70
39137	Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical repositioning of, to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, other than a service to which item 39130, 39138 or 39139 applies (H) (Anaes.) (Assist.)	$1,351.00
39138	Peripheral nerve lead or leads, surgical placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain where the leads are intended to remain in situ long term (H) (Anaes.) (Assist.)	$1,605.00
39139	Epidural lead, surgical placement of one or more of by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.)	$2,058.00
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (H) (Anaes.)	$654.90
39141	Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending remotely by video conference, for the management of chronic neuropathic pain or pain from refractory angina pectoris each day	$275.80
39300	Nerve, digital or cutaneous, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies applicable once per nerve (H) (Anaes.) (Assist.)	$837.90
39303	Nerve, digital or cutaneous, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve to facilitate repair; other than a service associated with a service to which item 30023 applies that is performed at the same site applicable once per nerve (H) (Anaes.) (Assist.)	$1,071.30
39306	Nerve trunk, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	$1,525.20
39307	Reconstruction of nerve trunk using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	$1,874.90
39309	Nerve trunk, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve or nerve transfer to facilitate repair; other than a service associated with: (c) a service to which item 39321 applies; or (d) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$1,645.60
39312	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques, other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$940.80
39315	Nerve trunk, nerve graft to, by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with: (e) a service to which item 39330 applies; or (f) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$2,449.70
39318	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft; other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	$1,510.20
39319	Reconstruction of digital or cutaneous nerve using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	$1,060.30
39321	Transposition of nerve, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	$1,094.60
39323	Percutaneous denervation (excluding medial branch nerve) by cryotherapy or radiofrequency probe, other than a service to which another item applies, applicable not more than 6 times for a given nerve in a 12 month period (Anaes.)	$657.30

Item No.	Description	Max Fee (excl. GST)
39324	Neurectomy or removal of tumour or neuroma from superficial peripheral nerve (Anaes.) (Assist.)	$658.50
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.)	$1,090.00
39328	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation, for upper limb surgery (H) (Anaes.) (Assist.)	$1,077.70
39329	Extensive neurolysis of radial, median or ulnar nerve trunk nerve in the forearm or arm, other than a service associated with: (a) a service to which item 39303, 39309, 39312, 39315, 39318, 39324 or 39327 applies; or (b) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$804.00
39330	Neurolysis by open operation without transposition, other than a service associated with: (a) a service to which item 39321, 39328, 39329, 39332, 39336, 39339, 39342, 39345, 49774 or 49775 applies; or (b) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$672.80
39331	Carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with: (c) a service to which item 46339 applies; or (d) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.)	$632.10
39332	Revision of carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with: (c) a service to which item 46339 applies; or (d) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$944.60
39336	Ulnar nerve decompression at elbow or wrist (cubital tunnel or Guyon s canal) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.)	$629.60
39339	Revision of ulnar nerve decompression at elbow (cubital tunnel) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$944.60
39342	Ulnar nerve decompression at elbow (cubital tunnel), including any of the following (if performed): (a) associated transposition; (b) subcutaneous or submuscular transposition of the nerve; (c) medial epicondylectomy; (d) ostetomy and reconstruction of the flexor origin; (e) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$1,239.10
39345	Localised decompression of radial, median or ulnar nerve, or branches of, in the forearm for compressive neuropathy, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$629.60
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.)	$2,135.80
39604	Any of the following procedures for intracranial haemorrhage or swelling: (a) craniotomy, craniectomy or burr-holes for removal of intracranial haemorrhage, including stereotaxy; (b) craniotomy or craniectomy for brain swelling, stroke, or raised intracranial pressure, including for subtemporal decompression, including stereotaxy; or (c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak. (Anaes.) (Assist.)	$3,928.80
39610	Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.)	$2,092.00
39612	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.)	$2,619.70
39615	Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.)	$3,281.40
39638	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, principal surgeon (Anaes.) (Assist.)	$9,325.20
39639	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, co surgeon (Assist.)	$7,451.90
39641	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty - one surgeon (Anaes.) (Assist.)	$9,835.80
39651	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty - one surgeon (Anaes.) (Assist.)	$12,134.70
39654	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, principal surgeon (Anaes.) (Assist.)	$9,388.80
39656	Petro clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, co surgeon (Assist.)	$7,603.70
39700	Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$1,744.60
39703	Intracranial tumour, cyst or other brain tissue, either or both of: (a) burr hole and biopsy of; (b) drainage of; including stereotaxy (Anaes.) (Assist.)	$1,558.90

Item No.	Description	Max Fee (excl. GST)
39710	Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$5,308.50
39712	Transcranial tumour removal or biopsy of one or more of any of the following: (a) meningioma; (b) pinealoma; (c) cranio pharyngioma; (d) pituitary tumour; (e) intraventricular lesion; (f) brain stem lesion; (g) any other intracranial tumour; by any means (with or without endoscopy), through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$7,777.20
39715	Pituitary tumour, removal of, by transphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$5,605.90
39718	Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.)	$2,716.90
39720	Awake craniotomy for functional neurosurgery (Anaes.) (Assist.)	$7,585.30
39801	Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$12,134.70
39803	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (Anaes.) (Assist.)	$7,758.40
39815	Carotid cavernous fistula, obliteration of combined cervical and intracranial procedure (H) (Anaes.) (Assist.)	$4,278.70
39818	Intracranial vascular bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.)	$5,588.50
39821	Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.)	$5,897.90
39900	Intracranial infection, treated by burr hole, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$1,410.80
39903	Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$4,304.60
39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$1,779.10
40004	Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.) (Assist.)	$3,624.10
40012	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.)	$2,799.90
40018	Lumbar cerebrospinal fluid drain, insertion of, other than a service associated with a service to which item 22053 applies (H) (Anaes.)	$356.70
40104	Spinal myelomeningocele or spinal meningocele, excision and closure of, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$2,223.80
40106	Chiari malformation, decompression or reconstruction of, including laminectomy, dermofat graft and stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$3,759.70
40109	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (Anaes.) (Assist.)	$4,043.10
40112	Tethered cord, release of, including lipomeningocele or diastematomyelia, multiple levels, including laminectomy and rhizolysis, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$3,956.80
40119	Craniostenosis, operation for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$2,092.00
40600	Cranioplasty, reconstructive, other than a service associated with a service to which item 39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803, 40703 or 41887 applies (H) (Anaes.) (Assist.)	$2,164.80
40700	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.)	$5,523.10
40701	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, subcutaneous placement of electrical pulse generator, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)	$758.80
40702	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)	$355.10
40703	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$4,120.40
40704	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)	$1,502.10

Item No.	Description	Max Fee (excl. GST)
40705	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of lead attached to left vagus nerve for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)	$1,348.70
40706	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.)	$5,511.60
40707	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, electrical analysis and programming of vagus nerve stimulation therapy device using external wand, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery	$422.70
40708	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treating refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)	$758.80
40709	Intracranial electrode placement by burr hole, including stereotaxy (Anaes.) (Assist.)	$1,869.10
40712	Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including stereotaxy (Anaes.) (Assist.)	$3,795.10
40801	Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production, by any method, in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson s disease, essential tremor or dystonia (Anaes.) (Assist.)	$4,699.50
40803	Intracranial stereotactic procedure by any method, other than: (a) a service to which item 40801 applies; or (b) a service associated with a service to which item 39018, 39109, 39113, 39604, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39818, 39821, 39900, 39903, 40004, 40012, 40106, 40109, 40700, 40703, 40706, 40709 or 40712 applies (H) (Anaes.) (Assist.)	$2,689.40
40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.)	$5,365.20
40851	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)	$10,621.10
40852	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)	$912.60
40854	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$1,226.40
40856	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$687.10
40858	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension lead for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$1,393.90
40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$4,816.90
40862	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$442.00
40863	Deep brain stimulation (unilateral), remote electronic analysis and programming of neurostimulator pulse generator for the treatment of: (a) Parkinson s disease, if the patient s response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient s symptoms cause severe disability Applicable not more than 8 times in any 12 month period	$409.10
40905	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.)	$1,408.90

Item No.	Description	Max Fee (excl. GST)
	Ear, nose and throat	
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)	$192.90
41501	Examination of glottal cycles and vibratory characteristics of the vocal folds by a specialist in the practice of the specialist's specialty of otolaryngology using videostroboscopy, including capturing audio, video, frequency and intensity, for confirmation of diagnosis , or for confirmation of treatment effectiveness where there is failure to progress or respond as expected, for: dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or benign or malignant vocal fold lesions; or premalignant or malignant laryngeal lesions; or vocal fold motion impairment or glottal insufficiency; or evaluation of vocal fold function after treatment or phonosurgery other than a service associated with a service to which item 41764 applies or with a services associated with the administration of a general anaesthetic	$400.50
41503	Ear, foreign body in (other than ventilating tube), removal of, involving incision of external auditory canal, other than a service associated with a service to which another item in this Subgroup applies (Anaes.)	$567.20
41506	Aural polyp, removal of (Anaes.)	$342.90
41509	External auditory meatus, surgical removal of keratosis obturans from, performed under general anaesthesia, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 41647 applies (H) (Anaes.)	$381.30
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)	$1,400.80
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.)	$899.60
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)	$2,215.70
41521	Correction of auditory canal stenosis, including meatoplasty, with or without grafting, other than a service associated with a service to which an item in Subgroup 18 applies (H) (Anaes.) (Assist.)	$2,331.10
41524	Reconstruction of external auditory canal (H) (Anaes.) (Assist.)	$675.10
41539	Ossicular chain reconstruction, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.)	$2,455.10
41542	Ossicular chain reconstruction and myringoplasty, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.)	$2,850.80
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.)	$1,641.20
41569	Decompression of facial nerve in its mastoid portion, other than a service associated with a service to which item 41617 applies (H) (Anaes.) (Assist.)	$2,831.60
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.)	$2,457.00
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.)	$5,829.70
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.)	$8,157.70
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.)	$5,581.80
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.)	$4,187.80
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.)	$6,668.00
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.)	$4,397.80
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.)	$6,229.20
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.)	$2,701.60
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.)	$3,644.90
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.)	$3,992.00
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.)	$3,992.00

Item No.	Description	Max Fee (excl. GST)
41603	Osseo integration procedure implantation of bone conduction hearing system device, in a patient: (a) with a permanent or long term hearing loss; and (b) unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) with bone conduction thresholds that accord with recognised criteria for the implantable bone conduction hearing device being inserted; other than a service associated with a service to which item 41554, 45794 or 45797 applies (H) (Anaes.)	$1,454.00
41608	STAPEDECTOMY (Anaes.) (Assist.)	$2,465.50
41611	Stapes mobilisation, other than a service associated with a service to which item 41539, 41542, or an item in Subgroup 18, applies (H) (Anaes.) (Assist.)	$1,676.10
41614	Round window surgery including repair of cochleotomy, other than a service associated with a service to which item 41617 applies (H) (Anaes.) (Assist.)	$2,592.50
41615	Oval window surgery, including repair of fistula, other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$2,595.20
41617	Cochlear implant, insertion of, including mastoidectomy, cochleotomy and exposure of facial nerve where required, other than a service associated with a service to which item 41569 or 41614 applies (H) (Anaes.) (Assist.)	$4,538.10
41618	Middle ear implant, partially implantable, insertion of, via mastoidectomy, for patients with: (a) stable sensorineural hearing loss; and (b) outer ear pathology that prevents the use of a conventional hearing aid; and (c) a PTA4 of less than 80 dBHL; and (d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5 4kHz) of each other; and (e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and (f) a normal middle ear; and (g) normal tympanometry; and (h) on audiometry, an air bone gap of less than 10 dBHL (0.5 4kHz) across all frequencies; and (i) no other inner ear disorders (Anaes.) (Assist.)	$4,181.60
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.)	$1,962.20
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.)	$2,665.00
41626	Incision of tympanic membrane, or installation of therapeutic agent, to the middle ear through an intact drum: (a) not including local anaesthetic; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 41632 applies (Anaes.)	$341.60
41632	Middle ear, insertion of tube for drainage of (including myringotomy), other than a service associated with a service to which item 41626 applies (Anaes.)	$533.20
41641	Perforation of tympanum, cauterisation or diathermy of (Anaes.)	$109.10
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.)	$338.70
41647	Micro inspection of tympanic membrane and auditory canal, requiring use of operating microscope or endoscope, including any removal of wax, with or without general anaesthesia, other than a service associated with a service to which item 41509 applies. Not applicable for the removal of uncomplicated wax in the absence of other disorders of the ear (Anaes.)	$257.40
41650	Tympanic membrane, microinspection of one or both ears under general anaesthesia, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$253.40
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)	$291.30
41659	Nose, removal of foreign body in, other than by simple probing (Anaes.)	$173.40
41662	Nasal polyp or polypi (simple), removal of, other than a service associated with a service to which item 41702, 41703 or 41705 applies on the same side	$188.30
41668	Nasal polyp or polypi, removal of (Anaes.)	$501.60
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (Anaes.)	$239.30
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$215.30
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.)	$263.00
41686	Dislocation of turbinate or turbinates, one or both sides, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$172.00
41698	Maxillary antrum, proof puncture and lavage of, other than a service associated with a service to which item 41702, 41703, 41705, 41710, 41734 or 41737 applies on the same side (Anaes.)	$77.70
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.)	$218.90

Item No.	Description	Max Fee (excl. GST)
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.)	$86.40
41707	Maxillary or sphenopalatine artery, ligation of (H) (Anaes.) (Assist.)	$1,064.70
41713	Vidian neurectomy or exposure of vidian canal (H) (Anaes.) (Assist.)	$1,440.70
41719	Antrum, drainage of, through tooth socket, other than a service associated with a service to which item 41722 applies (Anaes.)	$276.90
41722	Oroantral fistula, plastic closure of, other than a service associated with a service to which item 41719 or 45009 applies (Anaes.) (Assist.)	$1,319.70
41725	Ligation of ethmoidal artery or arteries, anterior, posterior or both, by any approach (unilateral) (H) (Anaes.) (Assist.)	$1,066.30
41728	Removal of sinonasal or nasopharyngeal tumour, excluding inflammatory nasal polyps, by any approach (H) (Anaes.) (Assist.)	$2,143.50
41740	Frontal sinus, catheterisation of, other than a service associated with a service to which item 41749 applies on the same side (H) (Anaes.)	$140.80
41743	Frontal sinus, trephine of, other than a service associated with a service to which item 41749 applies on the same side (H) (Anaes.) (Assist.)	$804.00
41746	Paranasal sinus, radical obliteration of, including any graft harvest (H) (Anaes.) (Assist.)	$1,746.90
41749	Paranasal sinus, external operation on, unilateral, other than a service associated with a service to which item 41740 or 41743 applies on the same side (H) (Anaes.) (Assist.)	$1,439.50
41755	Eustachian tube, catheterisation of (Anaes.)	$110.40
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination, other than a service associated with a service to which item 41693, 41702, 41703, 41705, 41734 or 41737 applies (Anaes.)	$280.20
41768	Unilateral insertion of bioabsorbable implant for nasal airway obstruction due to lateral wall insufficiency confirmed by positive modified Cottle manoeuvre, if: (a) the procedure is provided by a specialist in the practice of the specialist's specialty of otolaryngology or plastic surgery; and (b) the patient has a self reported NOSE Scale score of equal to or greater than 55; and (c) NOSE Scale evidence (with or without photographic evidence demonstrating the clinical need for this service) is documented in the patient notes; and (d) the patient has not previously received a service to which item 41769 applies Applicable once per lifetime per nostril (Anaes.)	$356.50
41769	Bilateral insertion of bioabsorbable implant for nasal airway obstruction due to lateral wall insufficiency confirmed by positive modified Cottle manoeuvre, if: (a) the procedure is provided by a specialist in the practice of the specialist's specialty of otolaryngology or plastic surgery; and (b) the patient has a self reported NOSE Scale score of equal to or greater than 55; and (c) NOSE Scale evidence (with or without photographic evidence demonstrating the clinical need for this service) is documented in the patient notes; and (d) the patient has not previously received a service to which item 41768 applies Applicable once per lifetime (Anaes.)	$534.80
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)	$1,650.20
41776	Cricopharyngeal myotomy by any approach, including open inversion of pharyngeal pouch or endoscopic repair of pharyngeal pouch (H) (Anaes.) (Assist.)	$1,367.30
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)	$1,642.00
41785	Partial pharyngectomy, by any approach, with or without partial glossectomy (H) (Anaes.) (Assist.)	$2,528.10
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.)	$1,717.50
41789	Tonsils or tonsils and adenoids, removal of, in a patient aged less than 12 years (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.)	$688.70
41793	Tonsils or tonsils and adenoids, removal of, in a patient 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.)	$871.30
41797	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.)	$342.90
41801	Adenoids, removal of (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.)	$368.60
41804	Removal of lingual tonsil (H) (Anaes.)	$205.10
41807	Peritonsillar abscess (quinsy), incision of (Anaes.)	$156.40
41810	Uvulotomy or uvulectomy (H) (Anaes.)	$81.80

Item No.	Description	Max Fee (excl. GST)
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)	$846.40
41822	Oesophagoscopy, with rigid oesophagoscope, with or without biopsy, other than a service associated with a service to which item 30473 or 30478 applies (H) (Anaes.)	$514.80
41825	Removal of a foreign body from the pharynx, larynx or oesophagus, by any means, other than a service associated with a service to which item 30478 applies (H) (Anaes.) (Assist.)	$846.20
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	$116.40
41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (H) (Anaes.) (Assist.)	$847.50
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (H) (Anaes.)	$532.40
41834	Total laryngectomy, including cricopharyngeal myotomy and tracheo oesophageal puncture (H) (Anaes.) (Assist.)	$3,165.00
41837	Complete vertical hemi laryngectomy, involving removal of true and false vocal cords, including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.)	$2,784.20
41840	Total supraglottic laryngectomy, involving removal of ventricular folds, epiglottis and aryepiglottic folds including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.)	$3,633.70
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)	$3,187.00
41855	Microlaryngoscopy, by any approach, with or without biopsy (H) (Anaes.) (Assist.)	$667.40
41861	Microlaryngoscopy with complete removal of benign or malignant lesions of the larynx, including papillomata, by any approach or technique, unilateral, other than a service associated with a service to which item 41870 applies on the same side (H) (Anaes.) (Assist.)	$1,425.20
41867	Microlaryngoscopy, with partial or complete arytenoidectomy or arytenoid repositioning (H) (Anaes.) (Assist.)	$1,469.00
41870	Laryngeal augmentation or modification by injection techniques, other than a service associated with a service to which item 41879 applies or item 41861 applies on the same side (Anaes.) (Assist.)	$1,048.40
41873	Larynx, fractured, operation for (H) (Anaes.) (Assist.)	$1,393.50
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (H) (Anaes.) (Assist.)	$1,356.50
41879	Tracheoplasty, laryngoplasty or thyroplasty, not by injection techniques, including tracheostomy, other than a service associated with a service to which item 41870 applies (H) (Anaes.) (Assist.)	$2,235.40
41880	Tracheostomy by a percutaneous technique (H) (Anaes.)	$605.30
41881	Tracheostomy by open exposure of the trachea (H) (Anaes.) (Assist.)	$904.80
41884	Cricothyrostomy (H) (Anaes.)	$203.30
41885	Trache oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (H) (Anaes.) (Assist.)	$644.10
41886	Trachea, removal of foreign body in (H) (Anaes.)	$423.20
41887	Pituitary tumour, removal of, by trans-sphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, as part of conjoint surgery, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	$5,429.70
41888	Fractured skull, after trauma only, or spontaneous defects with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (H) (Anaes.) (Assist.)	$3,842.70
41890	Orbit, decompression of, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, one eye by endonasal approach (H) (Anaes.) (Assist.)	$2,569.30
41907	Nasal septum button, insertion of (Anaes.)	$292.80
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.)	$928.90
	Ophthalmology	
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)	$246.50
42504	Implantation of a micro-bypass glaucoma surgery device or devices into the suprachoroidal space or the trabecular meshwork, if conservative therapies have failed, are likely to fail, or are contraindicated (H) (Anaes.)	$649.00
42505	Complete removal of a micro bypass glaucoma surgery device or devices from the suprachoroidal space or the trabecular meshwork, with or without replacement, following device related medical complications necessitating complete removal (H) (Anaes.)	$655.20
42506	Eye, enucleation of, without insertion of implant (H) (Anaes.) (Assist.)	$1,141.20
42509	Eye, enucleation of, with insertion of non-integrated implant, without muscle attachment (H) (Anaes.) (Assist.)	$1,389.90

Item No.	Description	Max Fee (excl. GST)
42510	Eye, enucleation of, with insertion of coralline or other integrated implant, including: (a) for a coralline implant attachment of at least the 4 rectus muscles (with or without oblique muscles) to: (i) the implant; or (ii) the implant wrap; or (b) for another integrated implant fashioning of myoconjunctival insertion of extraocular muscles (H) (Anaes.) (Assist.)	$1,707.90
42512	Globe, evisceration of (H) (Anaes.) (Assist.)	$1,126.70
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.)	$1,452.70
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.)	$788.80
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.)	$2,847.60
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.)	$907.50
42530	Orbit, exploration of, requiring removal of bone (orbitotomy) for access, with subsequent drainage or biopsy, including repair of any bone or soft tissue surgical defect, other than a service associated with a service to which item 45590 or 45594 applies on the same side (H) (Anaes.) (Assist.)	$1,529.00
42533	Orbit, exploration of, without requiring removal of bone (orbitotomy) for access, with drainage or biopsy, including repair of any bone or soft tissue surgical defect (H) (Anaes.) (Assist.)	$964.10
42536	Orbit, exenteration of, including repair of any bone or soft tissue surgical defect, with or without skin graft and with or without temporalis muscle transplant (H) (Anaes.) (Assist.)	$1,984.30
42539	Orbit, exploration of, requiring removal of bone (orbitotomy) for access, with removal of tumour or foreign body (not incisional biopsy), including repair of any bone or soft tissue surgical defect (H) (Anaes.) (Assist.)	$2,803.90
42542	Orbit, exploration of anterior aspect, with removal of tumour or foreign body (not incisional biopsy), including repair of any bone or soft tissue surgical defect (H) (Anaes.) (Assist.)	$1,197.60
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.)	$2,102.80
42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.)	$2,897.40
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.)	$1,753.30
42551	Eye, penetrating wound or rupture of, not involving intraocular structures repair involving suture of cornea or sclera, or both, other than a service to which item 42632 applies (H) (Anaes.) (Assist.)	$1,502.20
42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.)	$1,752.00
42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.)	$2,448.70
42563	Intraocular foreign body, removal from anterior segment (H) (Anaes.) (Assist.)	$1,199.10
42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)	$2,448.70
42572	Orbital abscess or cyst, drainage of (Anaes.)	$273.40
42573	DERMOID, periorbital, excision of, on a patient 10 years of age or over (Anaes.)	$540.30
42574	Dermoid, orbital, excision of (H) (Anaes.) (Assist.)	$1,082.70
42575	Tarsal cyst, extirpation of (Anaes.)	$196.50
42576	Dermoid, periorbital, excision of, on a patient under 10 years of age (H) (Anaes.)	$683.40
42581	Ectropion or entropion, tarsal cauterisation of (Anaes.)	$266.20
42584	TARSORRHAPHY (Anaes.) (Assist.)	$659.30
42587	Trichiasis (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.)	$122.60
42588	Trichiasis (due to trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.)	$113.20
42590	Canthoplasty, medial or lateral, excluding when performed in conjunction with cosmetic blepharoplasty (Anaes.) (Assist.)	$792.00
42596	Lacrimal sac, excision of, or operation on (H) (Anaes.) (Assist.)	$1,198.20
42599	Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, one eye (H) (Anaes.) (Assist.)	$1,412.00
42602	Lacrimal canalicular system, establishment of patency by open operation, one eye (H) (Anaes.) (Assist.)	$1,501.90

Item No.	Description	Max Fee (excl. GST)
42605	Lacrimal canaliculus, immediate repair of (H) (Anaes.) (Assist.)	$1,071.10
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)	$720.50
42610	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage under general anaesthesia (H) (Anaes.)	$216.10
42611	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage under general anaesthesia (H) (Anaes.)	$343.40
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)	$114.90
42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare)	$162.50
42617	Punctum snip operation (Anaes.)	$308.40
42620	Punctum, occlusion of, by use of a plug (Anaes.)	$127.70
42622	Punctum, permanent occlusion of, by use of electrical cautery (Anaes.)	$186.50
42623	Dacryocystorhinostomy, external or endonasal approach, including any sinus, turbinate or uncinate operation performed by same surgeon for access, with or without silicone intubation/stenting (H) (Anaes.) (Assist.)	$1,571.80
42626	Dacryocystorhinostomy, if a previous dacryocystorhinostomy has been performed, external or endonasal approach, including any sinus, turbinate or uncinate operation performed by same surgeon for access, with or without silicone intubation/stenting (H) (Anaes.) (Assist.)	$2,682.70
42629	Dacryocystorhinostomy, with placement of a permanent bypass tube from the conjunctival sac to the nasal cavity (H) (Anaes.) (Assist.)	$1,903.00
42632	Conjunctival peritomy or repair of corneal laceration by conjunctival flap, other than a service associated with a service to which item 42686 applies (Anaes.)	$278.90
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.)	$714.80
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.)	$897.40
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.)	$1,165.00
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.)	$161.50
42647	Corneal scars, removal of, by partial keratectomy, other than a service associated with a service to which item 42686 or 42650 applies (Anaes.)	$456.50
42650	Cornea, epithelial debridement for corneal ulcer or corneal erosion (excluding after-care), other than a service associated with a service to which item 42647 applies (Anaes.)	$171.70
42651	Cornea, epithelial debridement for eliminating band keratopathy (Anaes.)	$384.10
42652	Corneal collagen cross linking, on a patient with a corneal ectatic disorder, with evidence of progression per eye (Anaes.)	$2,673.60
42653	CORNEA transplantation of (Anaes.) (Assist.)	$3,133.90
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.)	$3,729.80
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.)	$2,015.20
42665	Sclera, transplantation of, superficial or lamellar, including collection of donor material (H) (Anaes.) (Assist.)	$1,343.10
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	$334.60
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.)	$178.70
42672	Corneal incisions, to correct corneal astigmatism of more than 11/2 dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (H) (Anaes.) (Assist.)	$2,013.30
42673	Additional corneal incisions, to correct corneal astigmatism of more than 11/2 dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (H) (Anaes.) (Assist.)	$1,055.90
42676	Conjunctiva, biopsy of, as an independent procedure	$275.00
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.)	$146.10

Item No.	Description	Max Fee (excl. GST)
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO² or N²0 (Anaes.)	$704.00
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.)	$270.00
42686	Pterygium, removal of, other than a service associated with a service to which item 42632 or 42647 applies (Anaes.)	$611.30
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.)	$264.20
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.)	$657.30
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.)	$1,075.70
42698	Lens extraction, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (H) (Anaes.)	$1,646.40
42701	Intraocular lens, insertion of, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (H) (Anaes.)	$1,152.30
42702	Lens extraction and insertion of intraocular lens, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (H) (Anaes.)	$2,314.90
42703	Intraocular lens or iris prosthesis, insertion of, into the posterior chamber with fixation to the iris or sclera (H) (Anaes.) (Assist.)	$1,278.80
42704	Intraocular lens, removal or repositioning of by open operation other than a service associated with a service to which item 42701 applies (H) (Anaes.)	$1,080.30
42705	Lens extraction and insertion of intraocular lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with insertion of a micro-bypass glaucoma surgery device or devices into the suprachoroidal space or trabecular meshwork, in a patient diagnosed with open angle glaucoma who is not adequately responsive to topical anti glaucoma medications or who is intolerant of anti glaucoma medication (H) (Anaes.)	$1,694.80
42707	Intraocular lens, removal of and replacement with a different lens, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (H) (Anaes.)	$1,800.60
42710	Intraocular lens, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (H) (Anaes.) (Assist.)	$2,178.60
42713	Iris or ciliary body suturing, McCannel technique or similar, for: (a) fixation of intraocular lens; or (b) repair of iris defect or cyclodialysis cleft (H) (Anaes.) (Assist.)	$892.80
42716	Cataract, juvenile, removal of, including subsequent needlings (H) (Anaes.) (Assist.)	$2,727.40
42719	Either or both of the following, via a limbal approach by any method: (a) removal of capsular or lens material; (b) removal of vitreous; other than a service associated with a service to which item 42698, 42702, 42705, 42716, 42725 or 42731 applies (H) (Anaes.) (Assist.)	$1,233.90
42725	Vitrectomy via pars plana sclerotomy, including one or more of the following: (a) removal of vitreous; (b) division of vitreous bands; (c) removal of epiretinal membranes; (d) capsulotomy (Anaes.) (Assist.)	$3,187.30
42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.)	$3,392.00
42734	Capsulotomy, other than by laser, and other than a service associated with a service to which item 42725 or 42731 applies (H) (Anaes.) (Assist.)	$713.70
42743	Anterior chamber, irrigation of blood from, as an independent procedure (H) (Anaes.) (Assist.)	$1,502.20
42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering surgery (Anaes.)	$715.40
42746	Glaucoma filtering surgery, if conservative therapies have failed, are likely to fail, or are contraindicated (H) (Anaes.) (Assist.)	$2,265.70
42749	Glaucoma filtering surgery, if previous filtering surgery has been performed (H) (Anaes.) (Assist.)	$2,847.50
42750	Subconjunctival injection of antifibrotic agent following glaucoma filtering surgery, as an independent procedure (Anaes.)	$93.30
42752	Insertion of glaucoma drainage device incorporating an extraocular reservoir (H) (Anaes.) (Assist.)	$3,015.10
42755	Any of the following: (a) removal of glaucoma drainage device incorporating an extraocular reservoir; (b) insertion or removal of intraluminal stent; (c) tying off of lumenOne eye (H) (Anaes.) (Assist.)	$395.30
42758	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.)	$1,563.00
42761	Division of anterior or posterior synechiae, as an independent procedure, other than by laser (H) (Anaes.) (Assist.)	$1,233.90

Item No.	Description	Max Fee (excl. GST)
42764	Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (H) (Anaes.) (Assist.)	$1,232.20
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.)	$2,558.30
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$686.70
42773	Detached retina, pneumatic retinopexy for, as an independent procedure (Anaes.) (Assist.)	$2,140.90
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.)	$2,990.50
42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.)	$3,929.30
42782	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$908.50
42785	Laser Iridotomy - each treatment episode to 1 eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$814.50
42788	Laser capsulotomy each treatment episode to one eye, to a maximum of 2 treatments to that eye in a 2 year period other than a service associated with a service to which item 42702 applies (Anaes.) (Assist.)	$814.50
42791	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreolysis in the posterior vitreous cavity each treatment to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$814.50
42794	Division of suture by laser following glaucoma filtering surgery, each treatment to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)	$160.20
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.)	$2,492.10
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.)	$1,227.90
42805	Tantalum markers, surgical insertion to the sclera to localise the tumour base and to assist in planning radiotherapy of choroidal melanomas one or more of (H) (Anaes.)	$1,373.40
42808	Laser iridoplasty	$851.10
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)	$1,079.00
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)	$1,264.00
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.)	$1,076.40
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.)	$369.70
42815	VITREOUS CAVITY, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Anaes.) (Assist.)	$1,501.90
42818	Retina or ciliary body, cryotherapy to, as an independent procedure, or when performed in conjunction with item 42809 (Anaes.)	$1,394.40
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.)	$214.20
42824	Retrobulbar injection of alcohol or other drug, as an independent procedure	$167.00
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)	$1,389.90
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)	$1,624.00
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)	$1,605.00
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)	$1,961.60
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)	$448.80
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.)	$1,605.00

Item No.	Description	Max Fee (excl. GST)
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)	$1,946.70
42854	Ruptured medial palpebral ligament or ruptured extra ocular muscle, repair of (H) (Anaes.) (Assist.)	$935.20
42857	Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (H) (Anaes.) (Assist.)	$970.40
42860	Eyelid (upper or lower), scleral or Goretex or other non autogenous graft to, with recession of the lid retractors (H) (Anaes.) (Assist.)	$2,127.20
42863	Eyelid (upper or lower), recession of, by open operation on and direct release of the lid retractors, one eye (Anaes.) (Assist.)	$1,844.90
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, excluding when performed in conjunction with closure of the retractors using conjunctival approaches for fat pad reduction or orbital surgery (Anaes.) (Assist.)	$1,679.90
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)	$1,227.20
42872	Direct eyebrow lift in paretic states, or in involutional states, if: (a) vision is obscured as evidenced by the resting of upper lid skin on the eyelashes in straight ahead gaze; and (b) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	$540.20
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.	$1,017.70
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.	$1,272.40
43030	Paracentesis of anterior chamber or vitreous cavity, or both, for either or both of the following: (a) the injection of therapeutic substances; (b) the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes;as an independent procedure of the left eye	$526.30
43032	Paracentesis of anterior chamber or vitreous cavity, or both, for either or both of the following: (a) the injection of therapeutic substances; (b) the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes;as an independent procedure of the right eye	$526.30
43034	Paracentesis of anterior chamber or vitreous cavity, or both, for either or both of the following: (a) the injection of therapeutic substances; (b) the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes;as an independent procedure of the left eye, for a patient requiring the administration of anaesthetic by an anaesthetist (Anaes.)	$526.30
43036	Paracentesis of anterior chamber or vitreous cavity, or both, for either or both of the following: (a) the injection of therapeutic substances; (b) the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes;as an independent procedure of the right eye, for a patient requiring the administration of anaesthetic by an anaesthetist (Anaes.)	$526.30
43038	Intravitreal injection of therapeutic substances, or the removal of vitreous humour for diagnostic purposes, one or more of, as a procedure associated with other intraocular surgery of the left eye (Anaes.)	$526.30
43040	Intravitreal injection of therapeutic substances, or the removal of vitreous humour for diagnostic purposes, one or more of, as a procedure associated with other intraocular surgery of the right eye (Anaes.)	$526.30
43050	Choroidal detachment, repair by external drainage (H) (Anaes.) (Assist.)	$1,179.80
	Operations for osteomyelitis	
43521	OPERATION ON SKULL (Anaes.) (Assist.)	$1,056.60
43527	Operation on sternum, clavicle, rib, metacarpus, carpus, phalanx, metatarsus, tarsus, mandible or maxilla (other than alveolar margins), by open or arthroscopic means, for septic arthritis or osteomyelitis one approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.)	$810.70
43530	Operation on scapula, ulna, radius, tibia, fibula, humerus or femur, by open or arthroscopic means, for septic arthritis or osteomyelitis one approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.)	$810.70
43533	Operation on spine or pelvic bones, by open or arthroscopic means, for septic arthritis or osteomyelitis one approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.)	$1,336.70
	Paediatric	
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.)	$2,230.30
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.)	$2,374.70
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.)	$2,590.60
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)	$3,022.50

Item No.	Description	Max Fee (excl. GST)
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.)	$3,022.50
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.)	$2,806.30
43819	Agangliosis coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.)	$2,266.60
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)	$2,266.60
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.)	$2,590.60
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.)	$2,862.30
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.)	$2,230.30
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.)	$2,590.60
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.)	$3,238.10
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.)	$2,806.30
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.)	$4,317.60
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.)	$4,641.20
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.)	$1,187.60
43852	Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.)	$3,777.60
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)	$3,994.00
43858	Oesophageal atresia, cervical oesophagostomy for (Anaes.) (Assist.)	$1,402.90
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.)	$3,885.90
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.)	$2,914.30
43867	Gastroschisis or exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.)	$1,619.30
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.)	$2,266.60
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.)	$3,022.50
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.)	$2,590.60
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.)	$3,022.50
43882	Cloacal exstrophy, operation for (H) (Anaes.) (Assist.)	$3,885.90
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.)	$2,590.60
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.)	$4,317.60
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.)	$3,777.60
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.)	$3,777.60
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.)	$3,569.00
43915	Eventration, plication of diaphragm for (Anaes.) (Assist.)	$2,618.40
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)	$1,037.60
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)	$1,214.60
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.)	$2,266.60
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.)	$1,727.20

Item No.	Description	Max Fee (excl. GST)
43942	Abdominal wall vitello intestinal remnant, excision of (Anaes.)	$551.00
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.)	$2,266.60
43948	Umbilical granuloma, excision of, under general anaesthesia (Anaes.)	$324.10
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.)	$2,029.80
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.)	$2,482.60
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)	$2,698.30
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.)	$949.20
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)	$3,777.60
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.)	$4,317.60
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.)	$5,936.70
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)	$4,387.00
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)	$5,073.30
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.)	$4,317.60
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.)	$1,187.60
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.)	$3,022.50
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.)	$3,346.10
43990	Aganglionosis coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.)	$4,101.70
43993	Aganglionosis coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.)	$4,425.40
43996	Aganglionosis coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.)	$4,965.20
43999	Aganglionosis coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)	$620.90
44102	RECTUM, examination of, on a patient 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.)	$614.80
44105	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a patient 2 years of age or over (H) (Anaes.)	$104.90
44108	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months (H) (Anaes.) (Assist.)	$1,257.60
44111	Obstructed or strangulated inguinal hernia, laparoscopic or open repair of, at age less than 12 months, including orchidopexy when performed (H) (Anaes.) (Assist.)	$1,472.90
44114	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.)	$1,472.90
44130	Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (H) (Anaes.) (Assist.)	$1,048.20
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.)	$880.50
44136	Ingrown toe nail, operation for, under general anaesthesia (H) (Anaes.)	$382.30
	Amputations	
44325	Amputation of hand, transcarpal (H) (Anaes.) (Assist.)	$704.50
44328	Amputation of hand, proximal to wrist radiocarpal joint, through forearm (H) (Anaes.) (Assist.)	$834.50
44331	Amputation at shoulder (H) (Anaes.) (Assist.)	$1,376.10
44334	Interscapulothoracic amputation (H) (Anaes.) (Assist.)	$2,815.30
44338	Amputation of one digit of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	$342.50

Item No.	Description	Max Fee (excl. GST)
44342	Amputation of 2 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	$508.20
44346	Amputation of 3 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	$572.20
44350	Amputation of 4 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	$674.80
44354	Amputation of 5 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	$743.00
44358	Amputation of one ray of one foot, proximal to the metatarsal head, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover or recontouring with homodigital flaps (H) (Anaes.) (Assist.)	$499.50
44359	Amputation of one or more toes of one foot, or amputation at midfoot or hindfoot of one foot, for diabetic or other microvascular disease; (a) including any of the following (if performed): (i) resection of bone; (ii) excision of neuromas; (iii) excision of one or more bones of the foot; (iv) treatment of underlying infection; (v) skin cover or recontouring with homodigital flaps; and (b) excluding aftercare; applicable only once per foot per occasion on which the service is performed (H) (Anaes.) (Assist.)	$625.70
44361	Amputation of foot, at ankle or hindfoot, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover; (H) (Anaes.) (Assist.)	$916.50
44364	Amputation of foot, transtarsal, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover; (H) (Anaes.) (Assist.)	$702.40
44367	Amputation through thigh, at knee or below knee (H) (Anaes.) (Assist.)	$1,247.10
44370	Amputation at hip (H) (Anaes.) (Assist.)	$1,686.40
44373	Hindquarter, amputation of (H) (Anaes.) (Assist.)	$3,461.90
44376	Amputation stump, reamputation of, to provide adequate skin and muscle cover (H) (Assist.) Derived fee: 75% of the original amputation fee.	DF
	Plastic and reconstructive surgery	
45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in association with any of items 31356 to 31383 (Anaes.)	$1,220.10
45003	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31383 (Anaes.)	$1,426.50
45006	Single stage large myocutaneous flap repair to one defect (pectoralis major, latissimus dorsi, or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.)	$2,483.00
45009	Single stage local muscle flap repair to 1 defect, simple and small, other than a service associated with a service to which item 30278, 30281 or 41722 applies (H) (Anaes.) (Assist.)	$863.20
45012	Single stage large muscle flap repair to one defect (pectoralis major, gastrocnemius, gracilis or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.)	$1,574.00
45015	Muscle or myocutaneous flap, delay of (Anaes.)	$771.00
45018	Dermis, dermofat or fascia graft (other than transfer of fat by injection): (a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171; and (b) other than a service associated with a service to which item 39615, 39715, 40106 or 40109 applies; and (c) other than a service to which item 38502 applies (H) (Anaes.) (Assist.)	$1,225.20
45019	Full face chemical peel for severely sun damaged skin, if: (a) the damage affects at least 75% of the facial skin surface area; and (b) the damage involves photo-damage (dermatoheliosis); and (c) the photo-damage involves: (i) a solar keratosis load exceeding 30 individual lesions; or (ii) solar lentigines; or (iii) freckling, yellowing or leathering of the skin; or (iv) solar kertoses which have proven refractory to, or recurred following, medical therapies; and (d) at least medium depth peeling agents are used; and (e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the specialty of dermatology or plastic surgery. Applicable once only in any 12 month period (Anaes.)	$918.00
45021	Abrasive therapy for severely disfiguring scarring of face resulting from trauma, burns or acne, if sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes limited to one claim per patient per episode (Anaes.)	$398.60
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.)	$398.60

Item No.	Description	Max Fee (excl. GST)
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.)	$891.70
45027	Vascular anomaly, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (H) (Anaes.)	$269.30
45030	Vascular anomaly, of skin, mucous membrane and/or subcutaneous tissue, small, excision and suture of (Anaes.)	$304.90
45033	Vascular anomaly, large or involving deeper tissue including facial muscle, excision and suture of (H) (Anaes.) (Assist.)	$572.20
45035	Vascular anomaly, large, deep, and involving major neurovascular structures, excision of, including dissection of muscles, nerves or major vessels (H) (Anaes.) (Assist.)	$1,582.30
45036	Vascular anomaly, of neck, deep and involving major neurovascular structures, excision of, including dissection of cranial nerves and major vessels (H) (Anaes.) (Assist.)	$2,687.00
45045	Vascular anomaly on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)	$733.70
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.)	$1,806.50
45051	Contour reconstruction by open repair of contour defects, due to deformity, if: (a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and (b) insertion of a non-biological implant is required, other than one or more of the following: (i) insertion of a non-biological implant that is a component of another service specified in Group T8; (ii) injection of liquid or semisolid material; (iii) an oral and maxillofacial implant service to which item 52321 applies; (iv) a service to insert mesh; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$1,180.10
45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (H) (Anaes.) (Assist.)	$630.80
45060	Developmental breast abnormality, single stage correction of, if: (a) the correction involves either: (i) bilateral mastopexy for symmetrical tubular breasts; or (ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$2,770.20
45061	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$2,770.20
45062	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$2,004.50
45200	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31383 (Anaes.)	$676.10
45201	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373, 31376, 31378, 31380 or 31383)-may be claimed only once per defect (Anaes.)	$936.90
45202	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion in a patient, if the clinical relevance of the procedure is clearly annotated in the patient's record and either: (a) item 45201 applies and additional flap repair is required for the same defect; or (b) item 45201 does not apply and either: (i) the patient has severe pre-existing scarring, severe skin atrophy or sclerodermoid changes; or (ii) the repair is contiguous with a free margin (Anaes.)	$936.90
45203	Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31383 (Anaes.) (Assist.)	$965.30

Item No.	Description	Max Fee (excl. GST)
45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31383 (Anaes.)	$910.80
45207	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not in association with any of items 31356 to 31383 (Anaes.)	$904.30
45209	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure (H) (Anaes.) (Assist.)	$1,127.20
45212	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), subsequent stage of a multistage procedure (H) (Anaes.) (Assist.)	$559.30
45221	Direct flap repair, small (cross finger or similar), first stage (Anaes.)	$619.20
45224	Direct flap repair, small (cross finger or similar), second stage (Anaes.)	$266.90
45227	Indirect flap or tubed pedicle, formation of (H) (Anaes.) (Assist.)	$995.00
45230	Direct or indirect flap or tubed pedicle, delay of (Anaes.)	$493.20
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (H) (Anaes.) (Assist.)	$1,113.40
45239	Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap, not being a service associated with a service to which item 45497 applies (Anaes.)	$623.40
45440	Split thickness skin graft to a small defect that is: (a) less than 40mm in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) less than 80mm in diameter on any other part of the body (Anaes.) (Assist.)	$592.20
45443	Split thickness skin graft to a large defect that is: (a) 40mm or more in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) 80mm or more in diameter on any other part of the body (Anaes.) (Assist.)	$1,221.10
45451	Full thickness skin graft to one defect, with an average diameter of 5mm or more (Anaes.) (Assist.)	$1,127.00
45496	FLAP, free tissue transfer using microvascular techniques - revision of, by open operation (Anaes.)	$933.50
45497	Flap, free tissue transfer using microvascular techniques or any autologous breast reconstruction, revision of, by liposuction, other than a service associated with a service to which item 45239 applies (H) (Anaes.)	$730.00
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit; cannot be claimed by the same provider for both artery and vein (H) (Anaes.) (Assist.)	$2,589.20
45501	Microvascular anastomosis of artery or vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	$3,968.20
45502	Microvascular anastomoses of artery and vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, including anastomoses of all required vessels for that extremity or digit, unless a micro-arterial or micro-venous graft is being used, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	$5,075.90
45503	Micro-arterial or micro-venous graft using microsurgical techniques, if the graft is critical for restoration of blood supply, including harvest of graft and suturing of all related anastomoses (not to be claimed in the context of cardiac surgery) (H) (Anaes.) (Assist.)	$4,849.20
45504	Microvascular anastomosis of artery, vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than: (a) a service for the purpose of breast reconstruction; or (b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	$4,237.40
45505	Microvascular anastomoses of artery and vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than: (a) a service for the purpose of breast reconstruction; or (b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	$4,635.70
45507	Microvascular repair using microsurgical techniques, with restoration of continuity of artery and vein of distal extremity or digit, including anastomoses of all required vessels for that extremity or digit, other than a service associated with a service to which item 45564, 45565 or 45567 applies (H) (Anaes.) (Assist.)	$3,405.40
45510	Scar, of face or neck, not more than 3cm in length, revision of, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of the specialist's specialty (Anaes.)	$457.90
45512	SCAR, of face or neck, more than 3cm 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.)	$669.30

Item No.	Description	Max Fee (excl. GST)
45515	Scar, other than on face or neck, not more than 7cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a non rebatable procedure); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.)	$444.70
45518	Scar, other than on face or neck, more than 7cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a non rebatable procedure); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (H) (Anaes.)	$530.20
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.)	$2,307.80
45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis;other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.)	$1,620.70
45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia who are experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis;other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.)	$2,943.20
45524	Mammaplasty, augmentation (unilateral) in the context of: (a) breast cancer; or (b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds. Applicable only once per occasion on which the service is provided, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	$1,683.60
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	$2,040.50
45528	Mammaplasty, augmentation, bilateral (other than a service to which item 45527 applies), if: (a) reconstructive surgery is indicated because of: (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and (b) photographic or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	$2,533.30
45530	Post-mastectomy breast reconstruction, autologous (unilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45006 or 45012 applies (H) (Anaes.) (Assist.)	$2,491.40
45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion insertion of tissue expansion unit and all attendances for subsequent expansion injections, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	$2,915.30
45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion removal of tissue expansion unit and insertion of permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	$1,384.70
45545	Nipple or areola or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)	$1,406.20
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	$467.50
45548	Breast prosthesis, removal of, as an independent procedure (H) (Anaes.)	$713.30
45551	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (Anaes.) (Assist.)	$1,138.20
45553	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$1,510.60

Item No.	Description	Max Fee (excl. GST)
45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) the excised specimen is sent for histopathology and the volume removed is documented in the histopathology report; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$1,799.00
45556	Breast ptosis, correction of (unilateral), in the context of breast cancer or developmental abnormality, if photographic evidence (including anterior, left lateral and right lateral views) and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.)	$1,961.60
45558	Correction of bilateral breast ptosis by mastopexy, if: (a) at least two thirds of the breast tissue, including the nipple, lies inferior to the inframammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes Applicable only once per lifetime, other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.)	$2,942.40
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.)	$1,164.40
45561	Microvascular anastomosis of artery and/or vein, if considered necessary to salvage a vascularly compromised pedicled or free flap, either during the primary procedure or at a subsequent return to theatre (H) (Anaes.) (Assist.)	$4,017.90
45562	Free transfer of tissue (microvascular free flap) for non-breast defect involving raising of tissue on vascular pedicle, including direct repair of secondary cutaneous defect (if performed), other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	$2,616.90
45563	Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, or for genital reconstruction, including: (a) direct repair of secondary cutaneous defect (if performed); and (b) formal dissection of the neurovascular pedicle;other than a service performed on simple V-Y flaps or other standard flaps, such as rotation or keystone (H) (Anaes.) (Assist.)	$2,614.20
45564	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$5,780.20
45565	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	$4,538.80
45566	Insertion of a temporary prosthetic tissue expander which requires subsequent removal, including all attendances for subsequent expansion injections, other than a service for breast or post-mastectomy tissue expansion (H) (Anaes.) (Assist.)	$2,415.20
45567	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562, 45564 or 45565 applies single surgeon (H) (Anaes.) (Assist.)	$6,114.90
45568	Tissue expander, removal of, including complete excision of fibrous capsule if performed (H) (Anaes.) (Assist.)	$1,009.30
45571	Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, to be used following the harvest of an autologous flap, being a service associated with a service to which item 45530, 45531, 45562, 45564, 45565, 45567, 46080, 46082, 46084, 46086, 46088 or 46090 applies, including repair of the musculoaponeurotic layer of the abdomen (including insertion of prosthetic mesh if used) (H) (Anaes.) (Assist.)	$2,155.00

Item No.	Description	Max Fee (excl. GST)
45572	Intra-operative tissue expansion using a prosthetic tissue expander, performed under general anaesthetic or intravenous sedation during an operation, if combined with a service to which another item in Group T8 applies (including expansion injections), not to be used for breast tissue expansion (H) (Anaes.)	$651.70
45575	Facial nerve paralysis, free fascia graft for (H) (Anaes.) (Assist.)	$1,659.40
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.)	$1,987.80
45581	Facial nerve paralysis, excision of tissue for (H) (Anaes.)	$713.30
45584	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	$1,626.00
45585	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), other than a service associated with a service to which item 31525 or 31526 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	$1,626.00
45587	Meloplasty for correction of facial asymmetry if: (a) the asymmetry is secondary to trauma (including previous surgery), a congenital condition or a medical condition (such as facial nerve palsy); and (b) the meloplasty is limited to one side of the face (Anaes.) (Assist.)	$2,152.20
45588	Meloplasty (excluding browlifts and chinlift platysmaplasties), bilateral, if: (a) surgery is indicated to correct a functional impairment due to a congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$3,219.70
45589	Autologous fat grafting (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for either or both of the following purposes: (i) the correction of asymmetry arising from volume and contour defects in craniofacial disorders up to a total of 4 services if each service is provided at least 3 months after the previous service; (ii) the treatment of burn scar or associated skin graft in the context of scar contracture, contour deformity or neuropathic pain, for patients who have undergone a minimum of 3 months of topical therapies, including silicone and pressure therapy, with an unsatisfactory or minimal level of improvement up to a total of 4 services per region of the body (upper or lower limbs, trunk, neck or face) if each service provided per region of the body is provided at least 3 months after the previous such service; and (b) both: (i) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes; and (ii) for craniofacial disorders, evidence of diagnosis of the qualifying craniofacial disorder is documented in the patient notes (H) (Anaes.)	$1,383.90
45590	Orbital cavity, reconstruction of wall or floor, with or without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 42530 or 45594 applies on the same side (H) (Anaes.) (Assist.)	$1,171.30
45592	Orbital cavity, reconstruction of wall and floor with bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.)	$1,772.30
45594	Orbital cavity, exploration of wall or floor without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 42530, 45590 or 45592 applies on the same side (H) (Anaes.) (Assist.)	$830.70
45596	Hemimaxillectomy (H) (Anaes.) (Assist.)	$2,056.00
45597	Total maxillectomy (bilateral) (H) (Anaes.) (Assist.)	$2,822.30
45599	Mandible, total resection of, other than a service associated with a service to which item 45608 applies (H) (Anaes.) (Assist.)	$1,913.40
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)	$1,676.00
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	$1,397.20
45608	Mandible, segmental mandibular or maxilla reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (H) (Anaes.) (Assist.)	$1,946.20
45609	Mandible, maxilla or skull base, reconstruction of, using bony free flap, all osteotomies, shaping, inset and fixation by any means, including all necessary 3 dimensional planning, if performed in conjunction with one or more services covered by items 46060 to 46068 (H) (Anaes.) (Assist.)	$1,722.70
45611	Mandible, condylectomy of (H) (Anaes.) (Assist.)	$1,327.00
45614	Eyelid, reconstruction of a defect (greater than one quarter of the length of the lid) involving all 3 layers of the eyelid, if unable to be closed by direct suture or wedge excision, including all flaps and grafts that may be required (Anaes.) (Assist.)	$1,531.40

Item No.	Description	Max Fee (excl. GST)
45617	Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) history of a demonstrated visual impairment; (ii) intertriginous inflammation of the eyelid; (iii) herniation of orbital fat in exophthalmos; (iv) facial nerve palsy; (v) post traumatic scarring; (vi) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (v); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	$571.20
45620	Lower eyelid, reduction of, if: (a) the reduction is for: (i) herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring; or (ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	$790.50
45623	Ptosis of upper eyelid (unilateral), correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller s or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle; Not applicable to a service for repair of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.)	$1,635.10
45624	Ptosis of upper eyelid, correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller s or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle; if a previous ptosis surgery has been performed on that side (Anaes.) (Assist.)	$2,224.30
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.)	$422.40
45626	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.)	$754.70
45627	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.)	$703.70
45629	Symblepharon, grafting for (H) (Anaes.) (Assist.)	$1,164.40
45632	Rhinoplasty, partial, involving correction of one or both lateral cartilages, one or both alar cartilages or one or both lateral cartilages and alar cartilages, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	$1,274.50
45635	Rhinoplasty, partial, involving correction of bony vault only, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	$1,510.60
45641	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, with or without autogenous cartilage or bone graft from a local site (nasal), if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	$2,675.00
45644	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes; other than a service associated with a service to which item 45718 applies (H) (Anaes.) (Assist.)	$3,131.30
45645	Choanal atresia, repair of by puncture and dilatation (Anaes.)	$523.80
45646	Choanal atresia, correction by open operation with bone removal (H) (Anaes.) (Assist.)	$2,048.00
45650	Rhinoplasty, revision of, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	$346.20
45652	Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of (Anaes.)	$859.80
45653	Rhinophyma, shaving of (Anaes.)	$811.30
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.)	$1,188.40
45659	Correction of a congenital deformity of the ear if: (a) the patient is less than 18 years of age; and (b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$1,201.10
45660	External ear, complex total reconstruction of, using costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of the specialist's specialty (H) (Anaes.) (Assist.)	$6,845.20

Item No.	Description	Max Fee (excl. GST)
45661	External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and skin graft to cover cartilage (second stage) - performed by a specialist in the practice of the specialist's specialty (H) (Anaes.) (Assist.)	$3,035.30
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures, excluding eyelid wedge when performed in conjunction with a cosmetic eyelid procedure (Anaes.)	$772.90
45668	Vermilionectomy, by surgical excision (Anaes.)	$775.40
45669	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.)	$744.70
45671	Lip or eyelid reconstruction, single stage or first stage of a two-stage flap reconstruction of a defect involving all 3 layers of tissue, if the flap is switched from the opposing lip or eyelid respectively (H) (Anaes.) (Assist.)	$1,994.10
45674	Lip or eyelid reconstruction, second stage of a two-stage flap reconstruction, division of the pedicle and inset of flap and closure of the donor (H) (Anaes.)	$556.90
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.)	$1,147.40
45676	MACROSTOMIA, operation for (Anaes.) (Assist.)	$1,367.60
45677	Cleft lip, unilateral primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	$1,330.80
45680	Cleft lip, unilateral primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	$1,740.70
45683	Cleft lip, bilateral primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	$1,933.70
45686	Cleft lip, bilateral primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	$2,196.90
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)	$629.40
45692	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (H) (Anaes.)	$714.60
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	$1,127.70
45698	Cleft lip, primary columella lengthening procedure, bilateral (Anaes.)	$1,074.30
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	$2,434.50
45704	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (H) (Anaes.)	$713.90
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.)	$1,862.50
45710	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.)	$1,166.50
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.)	$1,323.30
45714	Oro-nasal fistula, repair of, including a local flap for closure (H) (Anaes.) (Assist.)	$1,750.00
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.)	$1,855.50
45718	Face, contour restoration of one region, for the correction of deformity using autogenous bone or cartilage, if the deformity: (a) is secondary to congenital absence of tissue; or (b) has arisen from: (i) trauma (other than from previous cosmetic surgery); or (ii) a diagnosed pathological process;other than a service associated with a service to which item 45644 or 45717 (alveolar bone grafting) applies (H) (Anaes.) (Assist.)	$2,663.90
45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site, if: (a) the deformity: (i) is secondary to congenital absence of tissue; or (ii) has arisen from trauma (other than from previous cosmetic surgery) or a diagnosed pathological process; and (b) the service is required for maintaining lip competency; and (c) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (H) (Anaes.) (Assist.)	$1,823.40
45767	Hypertelorism, correction of, using intracranial approach (H) (Anaes.) (Assist.)	$5,881.00
45773	Syndromic orbital dystopia, such as Treacher Collins Syndrome, bilateral facial or periorbital reconstruction, with bone grafts from a distant site (H) (Anaes.) (Assist.)	$4,106.00
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.)	$4,198.30
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)	$3,018.90

Item No.	Description	Max Fee (excl. GST)
45782	Fronto-orbital advancement (H) (Anaes.) (Assist.)	$2,340.50
45785	Cranial vault reconstruction for single suture synostosis (H) (Anaes.) (Assist.)	$3,906.00
45788	Glenoid fossa, construction of, from bone and cartilage graft, and creation of condyle and ascending ramus of mandible, in hemifacial microsomia, not including harvesting of graft material (H) (Anaes.) (Assist.)	$3,946.20
45791	Absent condyle and ascending ramus in craniofacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.)	$2,085.80
45794	Osseo integration procedure, first stage, implantation of fixture, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 applies (Anaes.)	$1,295.50
45797	Osseo integration procedure, second stage, fixation of transcutaneous abutment, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 applies (Anaes.)	$428.10
45801	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral cavity, removal from mucosa or submucosal tissues, if the removal is by surgical excision and suture (Anaes.)	$305.00
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.)	$550.00
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 if a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	$882.10
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 (H) (Anaes.) (Assist.)	$1,195.40
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 (H) (Anaes.) (Assist.)	$1,397.10
45815	Operation on: (a) mandible or maxilla (other than alveolar margins) for chronic osteomyelitis with radiological and laboratory evidence of osteomyelitis; or (b) mandible or maxilla for necrosis of the jaw from any cause including medication or radiation that requires debridement of the alveolar bone or beyond (Anaes.) (Assist.)	$852.00
45823	Arch bars or similar, one or more, that were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia, if the service is undertaken in the operating theatre of a hospital (H) (Anaes.)	$278.00
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)	$807.20
45827	Mylohyoid ridge, reduction of (H) (Anaes.) (Assist.)	$721.50
45829	Maxillary tuberosity, reduction of (Anaes.)	$550.70
45831	Papillary hyperplasia of the palate, surgical reduction of cannot be claimed more than once per occasion of service (H) (Anaes.) (Assist.)	$721.50
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)	$1,308.70
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.)	$1,128.40
45845	Osseo-integration procedure, intra-oral implantation of titanium or similar fixture to facilitate restoration of the dentition following: (a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or (b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth)Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.)	$1,198.10
45847	Osseo-integration procedure, fixation of transmucosal abutment to fixtures that are placed following: (a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or (b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth)Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.)	$416.50
45849	Maxillary sinus, allograft, bone graft or both, to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (H) (Anaes.) (Assist.)	$1,392.30
45851	Temporomandibular joint, manipulation of, as an independent procedure performed in the operating theatre of a hospital, other than a service associated with a service to which any other item in this Group applies (H) (Anaes.)	$342.80
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (H) (Anaes.) (Assist.)	$869.80

Item No.	Description	Max Fee (excl. GST)
45857	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or lysis and lavage or biopsy (including repositioning of meniscus where indicated) one or more such procedures of that joint, other than a service associated with any other arthroscopic or open procedure of the temporomandibular joint (H) (Anaes.) (Assist.)	$1,531.00
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (s) (Anaes.) (Assist.)	$695.10
45871	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (H) (Anaes.) (Assist.)	$3,419.70
45873	Temporomandibular joint, surgery of, involving procedures to which item 45871 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (H) (Anaes.) (Assist.)	$3,573.50
45874	Temporomandibular joint, including condylar head and glenoid fossa, total alloplastic replacement (H) (Anaes.) (Assist.)	$2,743.90
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser.	$100.70
45888	Removal of a deep foreign body using interventional imaging techniques (H)	$921.70
45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.)	$1,351.30
45894	Grafting (mucosa or split skin), in the oral cavity of a mucosal defect (Anaes.)	$468.80
45939	Cryosurgery of the peripheral branches of the trigeminal nerve for pain relief (H) (Anaes.) (Assist.)	$997.80
46050	Perforator flap, raising on a named source vessel, for pedicled transfer for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.)	$1,637.90
46052	Perforator Flap, such as anterolateral thigh flap or similar, raising in preparation for microsurgical transfer of a free flap for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.)	$516.90
46060	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesSingle surgeon (H) (Anaes.) (Assist.)	$5,542.70
46062	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesConjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$5,301.90
46064	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesConjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	$3,976.50
46066	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesConjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$7,952.60

Item No.	Description	Max Fee (excl. GST)
46068	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed;other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesConjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	$5,964.80
46070	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation, including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed;other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesConjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$7,952.60
46072	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed;other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesConjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	$5,964.80
46100	Excision of burnt tissue, or definitive burn wound closure, if: (a) the area of burn excised involves more than 1% of hands, face or anterior neck; and (b) the service is performed in conjunction with a service (the co-claimed service) to which any of items 46101 to 46135 (other than item 46112 or 46124) apply;other than a service to which item 46136 applies	DF
46101	Excision of burnt tissue, if the area of burn excised involves not more than 1% of the total body surface (Anaes.) (Assist.)	$702.80
46102	Excision of burnt tissue, if the area of burn excised involves more than 1% but less than 3% of the total body surface (H) (Anaes.) (Assist.)	$1,115.60
46103	Excision of burnt tissue, if the area of burn excised involves 3% or more but less than 10% of the total body surface (H) (Anaes.) (Assist.)	$1,223.70
46104	Excision of burnt tissue, if the area of burn excised involves 10% or more but less than 20% of the total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$1,866.70
46105	Excision of burnt tissue, if the area of burn excised involves 20% or more but less than 30% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$2,510.70
46106	Excision of burnt tissue, if the area of burn excised involves 30% or more but less than 40% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$3,155.40
46107	Excision of burnt tissue, if the area of burn excised involves 40% or more but less than 50% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$3,799.40
46108	Excision of burnt tissue, if the area of burn excised involves 50% or more but less than 60% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$4,442.00
46109	Excision of burnt tissue, if the area of burn excised involves 60% or more but less than 70% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$5,085.90
46110	Excision of burnt tissue, if the area of burn excised involves 70% or more but less than 80% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$5,794.70
46111	Excision of burnt tissue, if the area of burn excised involves 80% or more of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	$6,489.70
46112	Excision of burnt tissue, if the area of burn excised involves whole of face (excluding ears) may be claimed with any one of items 46101 to 46111, based on the percentage total body surface (excluding the face), other than a service associated with a service to which item 46100 applies and excluding aftercare (H) (Anaes.) (Assist.)	$3,582.80
46113	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is not more than 1% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.)	$702.80

Item No.	Description	Max Fee (excl. GST)
46114	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is more than 1% but not more than 3% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.)	$1,115.60
46115	Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 3% but not more than 10% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.)	$1,223.70
46116	Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 10% but less than 20% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$1,866.70
46117	Excised burn wound closure, if the defect area is 20% or more but less than 30% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$2,510.70
46118	Excised burn wound closure, if the defect area is 30% or more but less than 40% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$3,155.40
46119	Excised burn wound closure, if the defect area is 40% or more but less than 50% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$3,799.40
46120	Excised burn wound closure, if the defect area is 50% or more but less than 60% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$4,442.00
46121	Excised burn wound closure, if the defect area is 60% or more but less than 70% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$5,085.90
46122	Excised burn wound closure, if the defect area is 70% or more but less than 80% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$5,794.70
46123	Excised burn wound closure, if the defect area is 80% or more of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	$6,489.70
46124	Excised burn wound closure of whole of face, if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.)	$3,582.80
46125	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves less than 1% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.)	$702.80
46126	Non excisional debridement of superficial or mid dermal partial thickness burns, if the area of burn involves 1% or more but less than 3% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (H) (Anaes.) (Assist.)	$1,115.60
46127	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 3% or more but less than 10% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (H) (Anaes.) (Assist.)	$1,545.50
46128	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 10% or more but less than 30% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.)	$2,833.20
46129	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 30% or more of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.)	$5,184.60

Item No.	Description	Max Fee (excl. GST)
46130	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves less than 1% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.)	$702.80
46131	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 1% or more but less than 3% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.)	$1,115.60
46132	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 3% or more but less than 10% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.)	$1,223.70
46133	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 10% or more but less than 20% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings, excluding aftercare (H) (Anaes.) (Assist.)	$1,866.70
46134	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 20% or more but less than 30% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.)	$4,131.40
46135	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 30% or more of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.)	$6,489.70
46136	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, of whole of face, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.)	$3,582.80
46140	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is less than 1% of total body surface, including direct repair if performed (Anaes.) (Assist.)	$536.00
46141	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 1% or more but less than 3% of total body surface (H) (Anaes.) (Assist.)	$804.10
46142	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 3% or more but less than 10% of total body surface (H) (Anaes.) (Assist.)	$964.80
46143	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 10% or more but less than 20% of total body surface (H) (Anaes.) (Assist.)	$1,250.60
46150	Mandible or maxilla, procedure for advancement, retrusion or alteration of tilt, by osteotomy in standard planes, including fixation by any means (including application of distractors if used) one service per patient on the same occasion (H) (Anaes.) (Assist.)	$2,768.80
46151	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used) conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	$3,019.00
46152	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used) conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	$2,264.20
46153	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used) single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	$3,773.60
46154	Maxilla, procedure for reshaping arch of, by complex segmental osteotomies, including fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.)	$3,160.00
46155	Mandible, procedure for reshaping arch of, by complex segmental osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.)	$3,160.00
46156	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used) conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	$3,607.50

Item No.	Description	Max Fee (excl. GST)
46157	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used) conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	$2,705.70
46158	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used) single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	$4,509.20
46159	Midfacial osteotomies, Le Fort II or Le Fort III conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$3,989.60
46160	Midfacial osteotomies, Le Fort II or Le Fort III conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	$2,992.20
46161	Midfacial osteotomies, Le Fort II or Le Fort III single surgeon (H) (Anaes.) (Assist.)	$4,986.80
46170	Decompression of thoracic outlet, primary, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.)	$2,082.20
46171	Decompression of thoracic outlet, repeat (revision) procedure, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.)	$3,539.60
46172	Removal or debulking of brachial plexus tumour, involving intraneural dissection, either supraclavicular or infraclavicular dissection (H) (Anaes.) (Assist.)	$5,205.30
46173	Removal or debulking of brachial plexus tumour, involving intraneural dissection, both supraclavicular and infraclavicular dissection (H) (Anaes.) (Assist.)	$7,287.50
46174	Exploration of the brachial plexus, either supraclavicular or infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements (H) (Anaes.) (Assist.)	$5,205.30
46175	Exploration of the brachial plexus, both supraclavicular and infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements (H) (Anaes.) (Assist.)	$8,328.50
46176	Exploration of the brachial plexus, posterior subscapular approach, all necessary elements of the operation including (but not limited to): (a) resection of the first rib and/or second rib; and (b) vertebral laminectomies or facetectomies, if performed; and (c) any neurolyses performed; and (d) intraoperative neurophysiological recordings;excluding the following: (e) reconstruction of elements of the plexus; (f) spinal instrumentation (H) (Anaes.) (Assist.)	$2,082.20
46177	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, single surgeon (H) (Anaes.) (Assist.)	$3,539.60
46178	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$3,539.60
46179	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.)	$2,946.20
46180	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.)	$5,205.30
46181	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$5,205.30
46182	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.)	$4,341.30
46183	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.)	$6,246.40
46184	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$6,246.40
46185	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.)	$5,205.30
	Hand surgery	
46300	Arthrodesis of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy one joint (H) (Anaes.) (Assist.)	$903.20
46303	Arthrodesis of carpometacarpal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy one joint (H) (Anaes.) (Assist.)	$1,045.30

Item No.	Description	Max Fee (excl. GST)
46308	Volar plate or soft tissue interposition arthroplasty of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) realignment procedures; (b) tendon transfer; one joint (H) (Anaes.) (Assist.)	$1,197.70
46309	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer one joint (H) (Anaes.) (Assist.)	$1,183.40
46312	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer 2 joints of one hand (H) (Anaes.) (Assist.)	$1,609.00
46315	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer 3 joints of one hand (H) (Anaes.) (Assist.)	$2,161.50
46318	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer 4 joints of one hand (H) (Anaes.) (Assist.)	$2,716.50
46321	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; 5 joints of one hand (H) (Anaes.) (Assist.)	$3,224.50
46322	Revision of prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpal joint of hand, including any of the following (if performed): (a) bone grafting; (b) ligament reconstruction; (c) ligament realignment; (d) synovectomy; (e) tendon or ligament reconstruction; (f) tendon transfer; one joint (H) (Anaes.) (Assist.)	$1,796.60
46324	Prosthetic interpositional replacement of carpometacarpal joint, including either or both of the following (if performed): (a) ligament and tendon transfers; (b) rebalancing procedures (H) (Anaes.) (Assist.)	$2,184.40
46325	Excisional arthroplasty of carpometacarpal joint, including any of the following (if performed): (a) ligament and tendon transfers; (b) realignment procedures; (c) excision of adjacent trapezoid (H) (Anaes.) (Assist.)	$2,192.40
46330	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) joint stabilisation; (c) synovectomy; one joint (H) (Anaes.) (Assist.)	$804.00
46333	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy; (b) harvest of graft; (c) joint stabilisation; (d) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 apply one joint (H) (Anaes.) (Assist.)	$1,298.00
46335	Synovectomy of digital extensor tendons of hand, distal to wrist, for diagnosed inflammatory arthritis, including any of the following (if performed): (a) reconstruction of extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) a service to which item 30023 applies that is performed at the same site Applicable once per hand per occasion on which the service is performed (H) (Anaes.) (Assist.)	$1,060.60
46336	Synovectomy of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) capsulectomy; (b) debridement; (c) ligament or tendon realignment (or both); other than a service combined with a service to which item 46495 applies one joint (H) (Anaes.) (Assist.)	$702.20
46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed): (a) tenolysis; (b) release of median nerve and carpal tunnel; other than a service associated with: (c) a service to which item 39330 or 39331 applies; or (d) a service to which item 30023 applies that is performed at the same site Applicable once per wrist per occasion on which the service is performed (H) (Anaes.) (Assist.)	$1,059.10
46340	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for diagnosed inflammatory tenosynovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) if this service is performed on the wrist flexor tendons a service to which item 39331 applies; or (g) a service to which item 30023 applies that is performed at the same site one or more compartments per limb (H) (Anaes.) (Assist.)	$901.50
46341	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for non-inflammatory tenosynovitis or post traumatic synovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) if this service is performed on the wrist flexor tendons a service to which item 39331 applies; or (g) a service to which item 30023 applies that is performed at the same site one or more compartments per limb (H) (Anaes.) (Assist.)	$578.10
46342	Synovectomy of distal radioulnar or carpometacarpal joint of hand one or more joints (H) (Anaes.) (Assist.)	$1,059.10
46345	Resection arthroplasty of distal radioulnar joint of hand, partial or complete, including any of the following (if performed): (a) ligament or tendon reconstruction; (b) joint stabilisation; (c) synovectomy (H) (Anaes.) (Assist.)	$1,297.70

Item No.	Description	Max Fee (excl. GST)
46348	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on the same ray one ray (H) (Anaes.) (Assist.)	$558.80
46351	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 2 rays of one hand (H) (Anaes.) (Assist.)	$869.20
46354	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 3 rays of one hand (H) (Anaes.) (Assist.)	$1,155.90
46357	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 4 rays of one hand (H) (Anaes.) (Assist.)	$1,442.50
46360	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 5 rays of one hand (H) (Anaes.) (Assist.)	$1,729.20
46363	Trigger finger release, for stenosing tenosynovitis, including either or both of the following (if performed): (a) synovectomy; (b) synovial biopsy; one ray (Anaes.) (Assist.)	$484.00
46364	Digital sympathectomy of hand, using microsurgical techniques, other than a service associated with: (a) a service to which item 46363 applies; or (b) a service to which item 30023 applies that is performed at the same site one digit or palmer arch (or both) or radial or ulnar artery (or both) (H) (Anaes.) (Assist.)	$1,060.60
46365	Excision of rheumatoid nodules of hand one lesion (Anaes.) (Assist.)	$599.00
46367	De Quervain's release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis; (b) synovectomy of abductor pollicis longus tendons; (c) retinaculum reconstruction; other than a service associated with a service to which item 46339 applies (Anaes.) (Assist.)	$904.40
46370	Percutaneous fasciotomy for Dupuytren s contracture, by needle or chemical method, including either or both of the following (if performed): (a) immediate or delayed manipulation; (b) local or regional nerve block; one ray (Anaes.) (Assist.)	$291.00
46372	Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) one ray (H) (Anaes.) (Assist.)	$979.20
46375	Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 2 rays (H) (Anaes.) (Assist.)	$1,161.60
46378	Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 3 rays (H) (Anaes.) (Assist.)	$1,544.00
46379	Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 4 rays (H) (Anaes.) (Assist.)	$1,940.10
46380	Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 5 rays (H) (Anaes.) (Assist.)	$2,444.40
46381	Release of interphalangeal joint of hand, by open procedure, when performed in conjunction with an operation for Dupuytren s contracture one joint (H) (Anaes.) (Assist.)	$684.10
46384	Z-plasty or similar local flap procedure, when performed in conjunction with an operation for Dupuytren s contracture, including raising, transfer in-setting and suturing of both components (flaps) one Z-plasty or local flap procedure (H) (Anaes.) (Assist.)	$684.10
46387	Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one ray (H) (Anaes.) (Assist.)	$1,407.80
46390	Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 2 rays (H) (Anaes.) (Assist.)	$1,894.50
46393	Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 3 rays (H) (Anaes.) (Assist.)	$2,188.20

Item No.	Description	Max Fee (excl. GST)
46394	Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 4 rays (H) (Anaes.) (Assist.)	$2,718.60
46395	Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 5 rays (H) (Anaes.) (Assist.)	$3,387.90
46399	Osteotomy of phalanx or metacarpal of hand, with internal fixation one bone (H) (Anaes.) (Assist.)	$1,228.00
46401	Operative treatment of non-union of phalanx or metacarpal of hand, including internal fixation (if performed) (H) (Anaes.) (Assist.)	$945.50
46408	Reconstruction of tendon of hand or wrist, by tendon graft, including either or both of the following (if performed): (a) harvest of graft; (b) tenolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$1,643.00
46411	Reconstruction of complete flexor tendon pulley of hand or wrist, with graft, including harvest of graft (if performed) one pulley (H) (Anaes.) (Assist.)	$964.20
46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$1,253.90
46417	Transfer of tendon of hand or wrist, for restoration of hand or digit motion, including harvest of donor motor unit (if performed) one transfer (H) (Anaes.) (Assist.)	$1,155.90
46420	Primary repair of extensor tendon of hand or wrist one tendon (Anaes.) (Assist.)	$478.30
46423	Delayed repair of extensor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$772.50
46426	Primary repair of flexor tendon of hand or wrist, proximal to A1 pulley one tendon (H) (Anaes.) (Assist.)	$784.80
46432	Primary repair of flexor tendon of hand, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure one tendon (H) (Anaes.) (Assist.)	$1,292.70
46434	Delayed repair of flexor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$1,105.90
46438	Closed pin fixation of mallet finger (H) (Anaes.)	$367.20
46441	Open reduction of mallet finger, including any of the following (if performed): (a) joint release; (b) pin fixation; (c) tenolysis (H) (Anaes.) (Assist.)	$785.60
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.)	$671.00
46444	Reconstruction of Boutonniere or swan neck deformity of hand, including either or both of the following (if performed): (a) tendon graft harvest; (b) tendon transfer one joint (H) (Anaes.) (Assist.)	$1,147.50
46450	Tenolysis of extensor tendon of hand or wrist, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies that is performed at the same site; one ray (H) (Anaes.)	$541.10
46453	Tenolysis of flexor tendon of hand or wrist, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$875.80
46456	Percutaneous tenotomy of digit of hand (Anaes.)	$232.80
46464	Amputation of a supernumerary complete digit of hand (H) (Anaes.) (Assist.)	$538.30
46465	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps one ray (H) (Anaes.) (Assist.)	$545.40
46468	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 2 rays (H) (Anaes.) (Assist.)	$1,059.50
46471	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 3 rays (H) (Anaes.) (Assist.)	$1,297.70
46474	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 4 rays (H) (Anaes.) (Assist.)	$1,717.10
46477	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 5 rays (H) (Anaes.) (Assist.)	$2,113.40

Item No.	Description	Max Fee (excl. GST)
46480	Amputation of ray of hand, proximal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) recontouring; (c) resection of bone; (d) skin cover with local flaps one ray (H) (Anaes.) (Assist.)	$860.10
46483	Revision of amputation stump of hand to provide adequate cover, including any of the following (if performed): (a) bone shortening; (b) excision of nail bed remnants; (c) excision of neuroma (H) (Anaes.) (Assist.)	$684.10
46486	Accurate reconstruction of acute nail bed laceration using magnification (H) (Anaes.)	$500.10
46489	Secondary reconstruction of nail bed deformity using magnification, including removal of nail (if performed), other than a service associated with a service to which item 46513 or 45451 applies (H) (Anaes.) (Assist.)	$628.50
46492	Surgical correction of contracture of joint of hand, flexor or extensor tendon, involving tissues deeper than skin and subcutaneous tissue one joint (H) (Anaes.) (Assist.)	$807.00
46493	Resection of boss of metacarpal base of hand, including either or both of the following (if performed): (a) excision of ganglion; (b) synovectomy (H) (Anaes.) (Assist.)	$749.60
46495	Complete excision of one or more ganglia or mucous cysts of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) osteophyte resections (c) synovectomy other than a service associated with a service to which item 30107 or 46336 applies one joint (H) (Anaes.) (Assist.)	$462.10
46498	Excision of ganglion of flexor tendon sheath of hand, including any of the following (if performed): (a) flexor tenosynovectomy; (b) sheath excision; (c) skin closure by any method; other than a service associated with: (d) a service to which item 30107 applies; or (e) a service to which item 46363 applies that is performed on the same ray (Anaes.) (Assist.)	$521.10
46500	Excision of ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.)	$621.00
46501	Excision of ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 or 46325 applies (Anaes.) (Assist.)	$758.70
46502	Excision of recurrent ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy (H) (Anaes.) (Assist.)	$829.20
46503	Excision of recurrent ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 applies (H) (Anaes.) (Assist.)	$902.70
46504	Neurovascular island flap, heterodigital, for pulp re-innervation and soft tissue cover (H) (Anaes.) (Assist.)	$2,514.30
46507	Transposition or transfer of digit or ray on vascular pedicle of hand, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures (H) (Anaes.) (Assist.)	$3,490.40
46510	Surgical reduction of enlarged elements resulting from macrodactyly, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures one digit (H) (Anaes.) (Assist.)	$947.10
46513	Removal of nail of finger or thumb one nail (Anaes.)	$132.30
46519	Drainage of midpalmar, thenar or hypothenar spaces or dorsum of hand, excluding aftercare (Anaes.) (Assist.)	$315.50
46522	Open operation and drainage of infection for flexor tendon sheath of finger or thumb, including either or both of the following (if performed): (a) synovectomy; (b) tenolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one digit (H) (Anaes.) (Assist.)	$979.20
46525	Incision for pulp space infection of hand: (a) other than a service: (i) to which another item in this Group applies; or (ii) associated with a service to which item 30023 applies that is performed at the same site; and (b) excluding aftercare (H) (Anaes.)	$133.90
46528	Wedge resection for ingrowing nail of finger or thumb: (a) including each of the following: (i) excision and partial ablation of germinal matrix; (ii) removal of segment of nail; (iii) removal of ungual fold; and (b) including phenolisation (if performed) (Anaes.)	$396.70
46531	Partial resection of ingrowing nail of finger or thumb, including phenolisation (Anaes.)	$199.40
46534	Complete ablation of nail germinal matrix (H) (Anaes.) (Assist.)	$525.40
	Orthopaedic	
47000	Mandible, treatment of dislocation of, by closed reduction, requiring general anaesthesia or intravenous sedation, if performed in the operating theatre of a hospital (H) (Anaes.)	$153.30
47003	Treatment of dislocation of clavicle, by closed reduction (Anaes.)	$174.20

Item No.	Description	Max Fee (excl. GST)
47007	Repair of acromioclavicular or sternoclavicular joint dislocation (acute or chronic), by open, mini-open or arthroscopic technique, including either or both of the following (if performed): (a) ligament augmentation; (b) tendon transfers (H) (Anaes.) (Assist.)	$803.10
47009	Treatment of dislocation of shoulder, requiring general anaesthesia, other than a service to which item 47012 applies (H) (Anaes.)	$382.70
47012	Treatment of dislocation of shoulder, requiring general anaesthesia, by open reduction (H) (Anaes.) (Assist.)	$764.60
47015	Treatment of dislocation of shoulder, not requiring general anaesthesia	$174.20
47018	Treatment of dislocation of elbow, by closed reduction (Anaes.)	$434.80
47021	Treatment of dislocation of elbow, by open reduction (H) (Anaes.) (Assist.)	$629.20
47024	Treatment of dislocation of distal or proximal radioulnar joint, by closed reduction, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.)	$469.20
47027	Treatment of dislocation of distal or proximal radioulnar joint, by open reduction, including either or both of the following (if performed): (a) styloid fracture; (b) triangular fibrocartilage complex repair; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (H) (Anaes.) (Assist.)	$727.40
47030	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by closed reduction (Anaes.)	$442.20
47033	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by open reduction, including ligament repair (if performed) (H) (Anaes.) (Assist.)	$719.40
47042	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by closed reduction (Anaes.)	$235.20
47045	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) ligament repair; (d) volar plate repair (H) (Anaes.) (Assist.)	$413.70
47047	Treatment of dislocation of prosthetic hip, by closed reduction (Anaes.) (Assist.)	$738.80
47049	Treatment of dislocation of prosthetic hip, by open reduction (H) (Anaes.) (Assist.)	$984.90
47052	Treatment of dislocation of native hip, by closed reduction (Anaes.) (Assist.)	$960.60
47053	Treatment of dislocation of native hip, by open reduction, with internal fixation (if performed) (H) (Anaes.) (Assist.)	$1,280.40
47054	Treatment of dislocation of knee, by closed reduction, including application of external fixator (if performed) (H) (Anaes.) (Assist.)	$777.40
47057	Treatment of dislocation of patella, by closed reduction (Anaes.)	$260.50
47060	Treatment of dislocation of patella, by open reduction (H) (Anaes.) (Assist.)	$349.20
47063	Treatment of dislocation of ankle or tarsus, by closed reduction (Anaes.) (Assist.)	$521.40
47066	Treatment of dislocation of ankle or tarsus, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint (H) (Anaes.) (Assist.)	$804.00
47069	Treatment of dislocation of toe, by closed reduction one toe (Anaes.)	$145.40
47301	Treatment of fracture of middle or proximal phalanx, by closed reduction, requiring anaesthesia one bone (Anaes.)	$196.50
47304	Treatment of fracture of metacarpal, by closed reduction, requiring anaesthesia one bone (H) (Anaes.)	$224.10
47307	Treatment of fracture of phalanx or metacarpal, by closed reduction, including percutaneous K wire fixation (if performed) one bone (H) (Anaes.) (Assist.)	$452.70
47310	Treatment of fracture of phalanx or metacarpal, by open reduction, with internal fixation (H) (Anaes.) (Assist.)	$746.90
47313	Treatment of intra-articular fracture of phalanx or metacarpal, by closed reduction, including: (a) percutaneous K-wire fixation; and (b) external or dynamic fixation (if performed) (H) (Anaes.) (Assist.)	$724.40
47316	Treatment of intra articular fracture of phalanx or metacarpal, by open reduction with fixation, other than a service provided on the same occasion as a service to which item 47319 applies (H) (Anaes.) (Assist.)	$1,437.20
47319	Treatment of intra-articular fracture of proximal end of middle phalanx, by open reduction, with fixation, other than a service provided on the same occasion as a service to which item 47316 applies (H) (Anaes.) (Assist.)	$1,471.30
47348	Treatment of fracture of carpus (excluding scaphoid), by cast immobilisation, other than a service associated with a service to which item 47351 applies (Anaes.)	$220.20

Item No.	Description	Max Fee (excl. GST)
47351	Treatment of fracture of carpus (excluding scaphoid), by open reduction, with internal fixation (H) (Anaes.) (Assist.)	$526.60
47354	Treatment of fracture of carpal scaphoid, by cast immobilisation, other than a service associated with a service to which item 47357 applies (Anaes.)	$396.70
47357	Treatment of fracture of carpal scaphoid, by reduction, with fixation by any means (H) (Anaes.) (Assist.)	$889.00
47361	Treatment of fracture of distal end of radius or ulna (or both), by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies	$298.40
47362	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, requiring general or major regional anaesthesia, but excluding local infiltration, other than a service associated with a service to which item 47361, 47364, 47367, 47370 or 47373 applies (Anaes.)	$447.20
47364	Treatment of fracture of distal end of radius or ulna (not involving joint surface), by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	$634.00
47367	Treatment of fracture of distal end of radius, by closed reduction with percutaneous fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	$506.40
47370	Treatment of intra articular fracture of distal end of radius, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	$918.80
47373	Treatment of intra articular fracture of distal end of ulna, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	$656.50
47381	Treatment of fracture of shaft of radius or ulna, by closed reduction (H) (Anaes.)	$604.50
47384	Treatment of fracture of shaft of radius or ulna, by open reduction with internal fixation (H) (Anaes.) (Assist.)	$804.90
47385	Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by closed reduction (H) (Anaes.) (Assist.)	$693.90
47386	Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by open reduction, with internal fixation, including reduction of dislocation (if performed) (H) (Anaes.) (Assist.)	$1,061.10
47387	Treatment of fracture of distal or shaft of radius or ulna (or both), by cast immobilisation, other than a service to which item 47390 or 47393 applies (Anaes.) (Assist.)	$638.90
47390	Treatment of fracture of shafts of radius and ulna, by closed reduction (H) (Anaes.)	$975.00
47393	Treatment of fracture of shafts of radius and ulna, by open reduction, with internal fixation (H) (Anaes.) (Assist.)	$1,301.10
47396	Treatment of fracture of olecranon, by closed reduction (Anaes.)	$440.60
47399	Treatment of fracture of olecranon, by open reduction (H) (Anaes.) (Assist.)	$879.40
47402	Treatment of fracture of olecranon, with excision of olecranon fragment and reimplantation of tendon (H) (Anaes.) (Assist.)	$739.50
47405	Treatment of fracture of head or neck of radius, by closed reduction (Anaes.)	$440.60
47408	Treatment of fracture of head or neck of radius, by open reduction, including internal fixation and excision (if performed) (H) (Anaes.) (Assist.)	$836.40
47411	Treatment of fracture of tuberosity of humerus, other than a service to which item 47417 applies (Anaes.)	$264.20
47414	Treatment of fracture of tuberosity of humerus, by open reduction (H) (Anaes.)	$556.80
47417	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	$627.10
47420	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	$1,351.50
47423	Humerus, proximal, treatment of fracture of, other than a service to which item 47426, 47429 or 47432 applies (Anaes.)	$513.50
47426	Humerus, proximal, treatment of fracture of, by closed reduction (H) (Anaes.)	$860.20
47429	Humerus, proximal, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	$986.50
47432	Humerus, proximal, treatment of intra articular fracture of, by open reduction (H) (Anaes.) (Assist.)	$1,289.50
47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (H) (Anaes.) (Assist.)	$924.40
47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	$1,579.00

Item No.	Description	Max Fee (excl. GST)
47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	$1,892.70
47444	Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.)	$513.80
47447	Humerus, shaft of, treatment of fracture of, by closed reduction (H) (Anaes.)	$812.00
47450	Humerus, shaft of, treatment of fracture of, by internal or external fixation (H) (Anaes.) (Assist.)	$1,016.20
47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.)	$1,216.70
47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, other than a service to which item 47456 or 47459 applies (Anaes.) (Assist.)	$617.10
47456	Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction (H) (Anaes.) (Assist.)	$946.60
47459	Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	$1,260.10
47462	Clavicle, treatment of fracture of, other than a service to which item 47465 applies (Anaes.)	$264.20
47465	Clavicle, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	$800.10
47466	Sternum, treatment of fracture of, other than a service to which item 47467 applies (Anaes.)	$264.20
47467	Sternum, treatment of fracture of, by open reduction (H) (Anaes.)	$504.00
47468	Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	$963.40
47471	RIBS (one or more), treatment of fracture of - each attendance	$100.70
47474	Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum	$450.90
47477	Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum (H)	$563.80
47480	PELVIC RING, treatment of fracture of, requiring traction (H) (Anaes.) (Assist.)	$1,147.70
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (H) (Anaes.) (Assist.)	$1,262.60
47486	Treatment of fracture of anterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.)	$2,233.70
47489	Treatment of fracture of posterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.)	$3,151.20
47491	Combined anterior and posterior pelvic ring disruption, including sacroiliac joint disruption, treatment of fracture by open reduction and internal fixation of both anterior and posterior ring segments (H) (Anaes.) (Assist.)	$3,533.80
47495	Treatment of fracture of acetabulum and associated dislocation of hip, including the application and management of traction (if performed), excluding aftercare (H) (Anaes.) (Assist.)	$1,059.90
47498	Treatment of isolated posterior wall fracture of acetabulum and associated dislocation of hip, by open reduction, with internal fixation, including the application and management of traction (if performed) (H) (Anaes.) (Assist.)	$1,575.60
47501	Treatment of anterior or posterior column fracture of acetabulum, by open reduction, with internal fixation, including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.)	$2,215.60
47511	Treatment of combined column T-Type, transverse, anterior column or posterior hemitransverse fractures of acetabulum, by open reduction, with internal fixation, performed through single or dual approach (including fixation of the posterior wall fracture), including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.)	$3,212.60
47514	Treatment of posterior wall fracture of acetabulum and associated femoral head fracture, by open reduction, with internal fixation (H) (Anaes.) (Assist.)	$1,873.90
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	$969.20
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (H) (Anaes.) (Assist.)	$2,057.90
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	$1,680.90
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.)	$2,143.50
47534	Femur, condylar region of, treatment of intra articular (T shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of one or more osteochondral fragments (H) (Anaes.) (Assist.)	$2,448.80
47537	Femur, condylar region of, treatment of fracture of, requiring internal fixation of one or more osteochondral fragments, other than a service associated with a service to which item 47534 applies (H) (Anaes.) (Assist.)	$1,031.00
47540	Hip spica or shoulder spica, application of, as an independent procedure (H) (Anaes.)	$515.70

Item No.	Description	Max Fee (excl. GST)
47543	Tibia, plateau of, treatment of medial or lateral fracture of, other than a service to which item 47546 or 47549 applies (Anaes.)	$529.20
47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (H) (Anaes.)	$756.60
47549	Treatment of medial or lateral fracture of plateau of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.)	$1,252.80
47552	Tibia, plateau of, treatment of both medial and lateral fractures of, other than a service to which item 47555 or 47558 applies (H) (Anaes.) (Assist.)	$841.60
47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (H) (Anaes.)	$1,262.60
47558	Treatment of medial and lateral fractures of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.)	$2,122.00
47559	Treatment of medial or lateral (or both) fracture of plateau of tibia, with application of a bridging external fixator to the plateau (H) (Anaes.) (Assist.)	$1,738.70
47561	Treatment of fracture of shaft of tibia, by cast immobilisation, other than a service to which item 47570 or 47573 applies (Anaes.)	$638.90
47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	$1,707.00
47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.)	$2,166.50
47568	Closed reduction of proximal tibia, distal tibia or shaft of tibia, with or without treatment of fibular fracture (H) (Anaes.) (Assist.)	$931.70
47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (H) (Anaes.) (Assist.)	$1,218.80
47573	Treatment of proximal or distal intra-articular fracture of shaft of tibia, by open reduction, with or without treatment of fibular fracture, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) capsule repair; (d) removal of intervening soft tissue; (e) removal of loose fragments; (f) washout of joint; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating a medial malleolus fracture of the distal tibia (H) (Anaes.) (Assist.)	$1,537.80
47577	Treatment of fracture of fibula proximal to ankle, by open reduction, with internal fixation, including any of the following (if performed): (a) internal fixation; (b) arthrotomy; (c) capsule repair; (d) removal of loose fragments or intervening soft tissue; (e) washout of joint (H) (Anaes.) (Assist.)	$1,076.30
47579	Treatment of fracture of patella, other than a service to which item 47582 or 47585 applies (Anaes.)	$374.80
47582	Treatment of fracture of patella, with internal fixation, including bone grafting (if performed), other than a service associated with a service to which item 47579 or 47585 applies (H) (Anaes.) (Assist.)	$926.10
47585	Treatment of proximal or distal fracture of patella, by open reduction, with internal fixation, including any of the following (if performed): (a) arthrotomy; (b) excision of patellar pole, with reattachment of tendon; (c) removal of loose fragments; (d) repair of quadriceps or patellar tendon (or both); (e) stabilisation of patello-femoral joint (H) (Anaes.) (Assist.)	$992.80
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 one or more ligaments (H) (Anaes.) (Assist.)	$2,943.50
47591	Knee joint, treatment of fracture of, by internal fixation of intra articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.)	$3,578.10
47592	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral or proximal tibial articular surfaces of the knee, when chondral or osteochondral implants or transfers are utilised (H) (Anaes.) (Assist.)	$741.60
47593	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral and proximal tibial articular surfaces of the knee, using chondral or osteochondral implants or transfers (H) (Anaes.) (Assist.)	$1,815.30
47595	Treatment of fracture of ankle joint, hindfoot, midfoot, metatarsals or toes, by non-surgical management one leg (Anaes.)	$366.50
47597	Treatment of fracture of ankle joint, by closed reduction (Anaes.) (Assist.)	$770.30
47600	Treatment of fracture of ankle joint: (a) by internal fixation of the malleolus, fibula or diastasis; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.)	$1,204.50
47603	Treatment of fracture of ankle joint: (a) by internal fixation of 2 or more of the malleolus, fibula, diastasis and medial tissue interposition; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.)	$1,536.10
47612	Treatment of intra-articular fracture of hindfoot, by closed reduction, with or without dislocation one foot (H) (Anaes.) (Assist.)	$938.10

Item No.	Description	Max Fee (excl. GST)
47615	Treatment of fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; one hindfoot bone (H) (Anaes.) (Assist.)	$1,059.90
47618	Treatment of intra-articular fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint one hindfoot bone (H) (Anaes.) (Assist.)	$1,415.40
47621	Treatment of intra-articular fracture of midfoot, by closed reduction, with or without dislocation one foot (H) (Anaes.) (Assist.)	$971.70
47624	Treatment of fracture of tarso-metatarsal, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint one joint (H) (Anaes.) (Assist.)	$1,278.90
47630	Treatment of fracture of cuneiform, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; one bone (H) (Anaes.) (Assist.)	$805.80
47637	Treatment of fractures of metatarsal, by closed reduction one or more metatarsals of one foot (Anaes.) (Assist.)	$436.40
47639	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed) one metatarsal of one foot (H) (Anaes.) (Assist.)	$518.20
47648	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed) 2 metatarsals of one foot (H) (Anaes.) (Assist.)	$702.90
47657	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed) 3 or more metatarsals of one foot (H) (Anaes.) (Assist.)	$1,050.00
47663	Treatment of fracture of phalanx of toe, by closed reduction one toe (Anaes.)	$331.00
47666	Treatment of fracture or dislocation of phalanx of great toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint; one great toe (H) (Anaes.)	$609.60
47672	Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint; one toe (other than great toe) of one foot (H) (Anaes.)	$256.80
47678	Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint; 2 or more toes (other than great toe) of one foot (H) (Anaes.)	$403.60
47735	Nasal bones, treatment of fracture of, other than a service to which item 47738 or 47741 applies each attendance	$96.60
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$629.80
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.)	$1,118.30
47753	Maxilla or mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	$1,070.00
47762	Zygomatic arch, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$590.00
47765	Zygomaticomaxillary complex/malar, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.)	$1,083.50
47766	Naso-orbital-ethmoidal complex, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.)	$1,251.20
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.)	$1,888.20
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.)	$1,631.30
47790	Tendon, large, lengthening of, as an independent procedure (H) (Anaes.) (Assist.)	$608.90
47791	Tenosynovectomy, not being a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$568.60
47792	Joint stabilisation procedure of acromioclavicular joint or sternoclavicular joint, including any of the following (if performed): (a) arthrotomy; (b) osteotomy, with or without fixation; (c) local tendon transfer; (d) local tendon lengthening or release; (e) ligament repair; (f) joint debridement; not being a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,015.30
47795	Joint stabilisation procedure of scapulothoracic joint, other than a service associated with a service to which another item in this Group (other than item 38828 or 48406) applies (H) (Anaes.) (Assist.)	$896.90
47900	Injection into, or aspiration of, unicameral bone cyst (Anaes.)	$403.90

Item No.	Description	Max Fee (excl. GST)
47903	Epicondylitis, open operation for (H) (Anaes.)	$602.00
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)	$132.30
47906	Digital nail of toe, removal of, in the operating theatre of a hospital (H) (Anaes.)	$270.40
47915	Wedge resection for ingrowing nail of toe: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and partial ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.)	$401.60
47916	Partial resection for ingrowing nail of toe, including phenolisation (Anaes.)	$199.40
47918	Complete ablation of nail germinal matrix: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.)	$562.80
47921	Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.)	$262.60
47924	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes), with incision, other than a service associated with a service to which item 47927 or 47929 applies one bone (Anaes.)	$89.60
47927	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes) one bone (H) (Anaes.)	$332.50
47929	Removal of fixation elements (including plate, rod or nail and associated wires, pins, screws or external fixation), other than a service associated with a service to which item 47924 or 47927 applies one bone (H) (Anaes.) (Assist.)	$856.60
47953	Repair of distal biceps brachii tendon, by any method, performed as an independent procedure (H) (Anaes.) (Assist.)	$984.90
47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item 39330 applies; or (b) a service to which another item in this Schedule applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region (Anaes.) (Assist.)	$914.40
47955	Repair of gluteal or rectus femoris tendon, by open or arthroscopic means, when performed as an independent procedure, including either or both of the following (if performed): (a) bursectomy; (b) preparation of greater trochanter; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	$1,482.30
47956	Repair of proximal hamstring tendon, performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	$2,223.70
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.)	$293.70
47964	Iliopsoas tenotomy, by open or arthroscopic means, when performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	$492.50
47967	Restoration of shoulder or elbow function by major muscle tendon transfer, including associated dissection of neurovascular pedicle, excluding micro-anastomosis and biceps tenodesis one transfer (H) (Anaes.) (Assist.)	$984.90
47968	Open tenotomy of one or more tendons of shoulder, with or without tenoplasty, to restore shoulder function, other than a service to which another item in this Group applies applicable once per joint per occasion on which this service is performed (Anaes.)	$412.60
47970	Open tenotomy of one or more tendons of scapula, with or without tenoplasty, to restore scapula function, other than a service to which another item in this Group applies applicable once per joint per occasion on which this service is performed (H) (Anaes.)	$412.60
47973	Open tenotomy of one or more tendons of elbow, with or without tenoplasty, to restore elbow function, other than a service to which another item in this Group applies applicable once per joint per occasion on which this service is performed (H) (Anaes.)	$412.60
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) (Assist.)	$837.10
47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.)	$585.40
47981	Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, other than a service to which another item in this Group applies (Anaes.)	$389.50
47982	Forage (Drill decompression), of neck or head of femur, or both (H) (Anaes.) (Assist.)	$817.50
47983	Stabilisation of slipped capital femoral epiphysis, by internal fixation (H) (Anaes.) (Assist.)	$1,970.50
47984	Open subcapital realignment of slipped capital femoral epiphysis, other than a service associated with a service to which item 48427 applies (H) (Anaes.) (Assist.)	$1,970.50

Item No.	Description	Max Fee (excl. GST)
48245	Harvesting and insertion of bone graft (autograft) via separate incisions and at separate surgical fields (H) (Anaes.) (Assist.)	$711.50
48248	Harvesting and insertion of bone graft (autograft) via separate incisions, including internal fixation of the graft or fusion fixation (or both) (H) (Anaes.) (Assist.)	$1,101.90
48251	Harvesting and insertion of osteochondral graft (autograft) via separate incisions at the same joint or joint complex (H) (Anaes.) (Assist.)	$906.80
48254	Harvesting and insertion of pedicled bone flap (autograft), including internal fixation of the bone flap (if performed), other than a service associated with a service to which item 45562, 45504 or 45505 applies (H) (Anaes.) (Assist.)	$2,077.50
48257	Preparation and insertion of metallic, cortical or other graft substitute (allograft), where substitute is structural cortico-cancellous bone or structural bone (or both), including internal fixation (if performed) (H) (Anaes.) (Assist.)	$906.80
48400	Operation on foot: (a) with either or both of the following: (i) osteotomy of phalanx or metatarsal for correction of deformity; (ii) excision of accessory bone or sesamoid bone; and (b) including any of the following (if performed): (i) removal of bone; (ii) excision of surrounding osteophytes; (iii) synovectomy; (iv) joint release; one bone (H) (Anaes.) (Assist.)	$762.10
48403	Osteotomy of phalanx of first toe or metatarsal, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; one bone (H) (Anaes.) (Assist.)	$1,240.50
48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; other than a service to which item 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764 applies one bone (H) (Anaes.) (Assist.)	$785.60
48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; other than a service to which item 38365, 38467, 38477, 38484, 38485, 38490, 38493, 38499, 38502, 38510, 38512, 38513, 38515, 38516, 38517, 38519, 38550, 38553, 38554, 38555, 38557, 38670, 38703, 38742 or 38764 applies one bone (H) (Anaes.) (Assist.)	$1,168.30
48412	Osteotomy of humerus, without internal fixation (H) (Anaes.) (Assist.)	$1,512.00
48415	Osteotomy of humerus, with internal fixation (H) (Anaes.) (Assist.)	$1,905.60
48419	Osteotomy of distal tibia, for correction of deformity, without internal or external fixation, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; one bone (H) (Anaes.) (Assist.)	$1,434.70
48420	Osteotomy of distal tibia, for correction of deformity, with internal or external fixation by any method, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; one bone (H) (Anaes.) (Assist.)	$1,820.40
48421	Osteotomy of proximal tibia, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.)	$2,082.00
48422	Osteotomy of distal femur, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.)	$2,077.50
48423	Osteotomy of pelvis, in a patient aged 18 years or over, including any of the following (if performed): (a) associated intra-articular procedures; (b) bone grafting; (c) internal fixation (H) (Anaes.) (Assist.)	$1,713.60
48424	Osteotomy of pelvis, in a patient aged less than 18 years, with application of hip spica, including internal fixation (if performed), other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$1,802.30
48426	Osteotomy of femur, in a patient aged 18 years or over, including either or both of the following (if performed): (a) bone grafting; (b) internal fixation (H) (Anaes.) (Assist.)	$2,077.50
48427	Osteotomy of femur, in a patient aged less than 18 years, including internal fixation (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$2,061.00
48430	Excision of one or more osteophytes of the foot or ankle, or simple removal of bunion, including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; each incision (H) (Anaes.) (Assist.)	$610.40
48433	Treatment of non-union or malunion, with preservation of the joint, for ankle or hindfoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; one bone (H) (Anaes.) (Assist.)	$2,431.00

Item No.	Description	Max Fee (excl. GST)
48435	Treatment of non-union or malunion, with preservation of the joint, for midfoot or forefoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; one bone (H) (Anaes.) (Assist.)	$1,285.00
48436	Excision of one or more exostoses of the hand, distal to the wrist, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of ligaments; (c) removal of one or more associated bursae or ganglia; (d) removal of bone; (e) synovectomy; other than a service associated with a service to which another item in this Schedule applies that: (f) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (g) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.)	$511.20
48438	Excision of one or more exostoses in the wrist including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48436 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.)	$511.20
48440	Excision of one or more exostoses in the arm or shoulder, including the radius, ulna, humerus, acromion, clavicle, or scapula, including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48438 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.)	$511.20
48442	Excision of one or more exostoses in the hip, including pelvis and femur, including any of following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48444 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.)	$511.20
48444	Excision of one or more exostoses in the knee, tibia or fibula, including any of following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which item 48430 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.)	$511.20
48446	Treatment of non-union or malunion of fracture of pelvis, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.)	$2,299.10
48448	Treatment of non-union or malunion of fracture of femur, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.)	$2,299.10
48450	Treatment of non-union or malunion of fracture of tibia or fibula, proximal to ankle, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.)	$2,083.80
48452	Treatment of non-union or malunion of fracture of humerus, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.)	$2,083.80
48454	Treatment of non-union or malunion of fracture of radius, ulna, or carpus including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.)	$1,545.70
48456	Treatment of non-union or malunion of fracture of hand, distal to wrist, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.)	$1,545.70
48507	Epiphysiodesis of a long bone, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	$833.10
48509	Hemiepiphysiodesis, partial growth plate arrest using internal fixation, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	$605.90

Item No.	Description	Max Fee (excl. GST)
48512	Epiphysiolysis, release of focal growth plate closure, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	$2,015.30
48900	Shoulder, excision of coraco acromial ligament or removal of calcium deposit from cuff or both (H) (Anaes.) (Assist.)	$635.10
48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.)	$1,302.50
48906	Shoulder, repair of rotator cuff, including excision of coraco acromial ligament or removal of calcium deposit from cuff, or both other than a service associated with a service to which item 48900 applies (H) (Anaes.) (Assist.)	$1,341.70
48909	Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item 48903 applies (H) (Anaes.) (Assist.)	$1,768.80
48915	Shoulder, hemi arthroplasty of (H) (Anaes.) (Assist.)	$1,737.90
48918	Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by open or arthroscopic means (H) (Anaes.) (Assist.)	$3,609.40
48919	Anatomic or reverse total shoulder replacement with bone graft, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with: (d) a service to which another item in this Schedule applies that is performed on the shoulder region by open or arthroscopic means; or (e) a service to which item 48245, 48248, 48251, 48254 or 48257 applies that is performed on the same joint (H) (Anaes.) (Assist.)	$3,250.10
48921	Shoulder, total replacement arthroplasty, revision of (H) (Anaes.) (Assist.)	$3,474.10
48924	Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus; (b) bone graft to scapula (H) (Anaes.) (Assist.)	$4,149.60
48925	Arthroplasty of shoulder, other than: (a) a service to which another item applies; or (b) a service associated with a service to which any of items 48900 to 48909, 48948, 48951, or 48960 applies that is performed on the same joint (H) (Anaes.) (Assist.)	$1,338.50
48927	Shoulder prosthesis, removal of (H) (Anaes.) (Assist.)	$859.70
48932	Arthroplasty of acromioclavicular joint or sternoclavicular joint, other than: (a) a service to which another item applies; or (b) a service associated with a service to which another item in this Schedule applies that is performed on the same joint by arthroscopic means one joint (H) (Anaes.) (Assist.)	$1,338.50
48939	Shoulder, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	$2,567.60
48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including either or both of the following (if performed): (a) removal of prosthesis; (b) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$3,155.80
48943	Arthrodesis of acromioclavicular or sternoclavicular joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; one joint (H) (Anaes.) (Assist.)	$896.90
48944	Arthrodesis of scapulothoracic joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; one joint (H) (Anaes.) (Assist.)	$896.90
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	$612.00
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	$1,390.60
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	$1,995.90
48952	Surgery of acromioclavicular joint or sternoclavicular joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies that is performed on the same joint by arthroscopic means (H) (Anaes.) (Assist.)	$1,166.00
48953	Surgery of scapulothoracic joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies that is performed on the same joint by arthroscopic means (H) (Anaes.) (Assist.)	$1,166.00
48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	$2,240.80

Item No.	Description	Max Fee (excl. GST)
48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or reattachment (if performed), excluding bone grafting and removal of hardware, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	$2,463.10
48959	Latarjet procedure by open or arthroscopic means, including any of the following (if performed) but excluding removal of hardware: (a) labral repair or reattachment; (b) bone grafting; (c) tendon transfer; other than a service associated with a service to which another item in this Schedule applies that is performed on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	$2,880.70
48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (H) (Anaes.) (Assist.)	$2,282.30
48972	Tenodesis of biceps, by open or arthroscopic means, performed as an independent procedure (H) (Anaes.) (Assist.)	$984.90
48980	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the shoulder girdle (H) (Anaes.) (Assist.)	$1,820.40
48983	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the elbow (H) (Anaes.) (Assist.)	$1,335.10
48986	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the forearm (H) (Anaes.) (Assist.)	$1,820.40
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.)	$768.70
49104	Repair of one or more ligaments of the elbow, for acute instability within 6 weeks after the time of injury (H) (Anaes.) (Assist.)	$1,204.60
49105	Stabilisation of one or more ligaments of the elbow, for chronic instability, including harvesting of tendon graft 6 weeks or more after the time of injury (H) (Anaes.) (Assist.)	$1,766.80
49106	Elbow, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	$2,106.10
49109	ELBOW, total synovectomy of (H) (Anaes.) (Assist.)	$1,717.40
49112	Radial head replacement of elbow, other than a service associated with a service to which item 49115 applies (H) (Anaes.) (Assist.)	$1,631.00
49113	Removal of radial head prosthesis (H) (Anaes.) (Assist.)	$1,338.50
49114	Revision of radial head replacement (H) (Anaes.) (Assist.)	$1,338.50
49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item 49112 applies (H) (Anaes.) (Assist.)	$2,819.40
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.)	$3,539.00
49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis (H) (Anaes.) (Assist.)	$4,208.30
49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)	$641.80
49121	Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty; (b) drilling of defect; (c) osteoplasty; (d) removal of loose bodies; (e) release of contracture or adhesions; (f) treatment of epicondylitis; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)	$1,477.60
49124	Excision of olecranon bursa, including bony prominence, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)	$845.20
49127	Elbow joint, arthroplasty of, other than a service to which another item applies (H) (Anaes.) (Assist.)	$1,338.50
49200	Wrist, arthrodesis of, with synovectomy if performed, with or without internal fixation of the radiocarpal joint (H) (Anaes.) (Assist.)	$1,836.30
49203	Limited fusion of wrist, with or without bone graft, including each of the following: (a) ligament or tendon transfers; (b) partial or total excision of one or more carpal bones; (c) rebalancing procedures; (d) synovectomy (H) (Anaes.) (Assist.)	$1,755.50
49206	Proximal row carpectomy of wrist, including either or both of the following (if performed): (a) styloidectomy; (b) synovectomy (H) (Anaes.) (Assist.)	$1,318.10

Item No.	Description	Max Fee (excl. GST)
49209	Prosthetic replacement of wrist or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment; (b) tendon realignment (H) (Anaes.) (Assist.)	$1,689.50
49210	Revision of total replacement arthroplasty of wrist or distal radioulnar joint, including any of the following (if performed): (a) ligament rebalancing; (b) removal of prosthesis; (c) tendon rebalancing (H) (Anaes.) (Assist.)	$2,221.40
49212	Arthrotomy of wrist or distal radioulnar joint, including any of the following (if performed): (a) joint debridement; (b) removal of loose bodies; (c) synovectomy (H) (Anaes.) (Assist.)	$537.00
49213	Sauve-Kapandji procedure of distal radioulnar joint, including any of the following (if performed): (a) radioulnar fusion; (b) osteotomy; (c) soft tissue reconstruction (H) (Anaes.) (Assist.)	$1,916.60
49215	Reconstruction of single or multiple ligaments or capsules of wrist, including any of the following (if performed): (a) arthrotomy; (b) ligament harvesting and grafting; (c) synovectomy; (d) tendon harvesting and grafting; (e) insertion of synthetic ligament substitute (H) (Anaes.) (Assist.)	$1,474.70
49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) other than a service associated with another arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	$668.70
49219	Diagnosis of carpometacarpal joint of thumb or joint of digit, by arthroscopic means, including biopsy (if performed) (H) (Anaes.) (Assist.)	$621.00
49220	Treatment of carpometacarpal joint of thumb or joint of digit, by arthroscopic means one joint (H) (Anaes.) (Assist.)	$1,392.10
49221	Treatment of wrist, by arthroscopic means, including any of the following (if performed): (a) drilling of defect; (b) removal of loose bodies; (c) release of adhesions; (d) synovectomy; (e) debridement; (f) resection of dorsal or volar ganglia; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	$1,409.30
49224	Osteoplasty of wrist, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna; (b) total synovectomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint 2 or more distinct areas (H) (Anaes.) (Assist.)	$1,633.90
49227	Treatment of wrist by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means; (b) stabilisation procedure for ligamentous disruption; (c) partial wrist fusion or carpectomy, by arthroscopic means; (d) fracture management; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	$1,666.90
49230	Total, hemi or interpositional prosthetic replacement of carpal bone of wrist, including any of the following (if performed): (a) ligament and tendon rebalancing procedures; (b) limited wrist fusions; (c) limited bone grafting (H) (Anaes.) (Assist.)	$2,095.80
49233	Excisional arthroplasty of single (or part of) carpal bone of wrist, when transfers of ligaments or tendons, or rebalancing procedures, are not required, including any of the following (if performed): (a) radial styloidectomy; (b) ulnar styloidectomy; (c) proximal hamate; (d) partial scaphoid; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a distal radioulnar joint reconstruction, a proximal row carpectomy or a limited wrist fusion applicable once for a single operation (H) (Anaes.) (Assist.)	$882.40
49236	Stabilisation of soft tissue of distal radioulnar joint, with or without ligament or tendon grafting, including either or both of the following (if performed): (a) graft harvest; (b) triangular fibrocartilage complex repair or reconstruction (H) (Anaes.) (Assist.)	$1,330.30
49239	Excision of pisiform or hook of hamate or sesamoid bone of hand, including release of ulnar nerve (if performed) (H) (Anaes.) (Assist.)	$661.70
49300	Sacro-iliac joint arthrodesis of (H) (Anaes.) (Assist.)	$1,363.70
49303	Arthrotomy of hip, by open procedure, including any of the following (if performed): (a) lavage; (b) drainage; (c) biopsy (H) (Anaes.) (Assist.)	$1,298.30
49306	Hip, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	$2,566.90
49309	Arthrectomy or excision arthroplasty (Girdlestone) of hip, other than a service performed: (a) for the purpose of implant removal; or (b) as stage 1 of a 2-stage procedure (H) (Anaes.) (Assist.)	$1,788.90
49315	Hip, arthroplasty of, unipolar or bipolar (H) (Anaes.) (Assist.)	$2,014.00
49318	Total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$3,150.90
49319	Bilateral total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$5,490.30

Item No.	Description	Max Fee (excl. GST)
49321	Complex primary arthroplasty of hip, with internal fixation, including either or both of the following (if performed): (a) structural bone graft; (b) insertion of synthetic substitutes or metal augments; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$3,576.30
49360	Diagnostic arthroscopy of hip, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure of the hip joint by arthroscopic means (H) (Anaes.) (Assist.)	$771.20
49363	Diagnostic arthroscopy of hip, with synovial biopsy, other than a service associated with a service to which another item in this Schedule applies that is performed on the hip joint by arthroscopic means (H) (Anaes.) (Assist.)	$993.30
49366	Treatment of hip, by arthroscopic means, including any procedures to treat bone or soft tissue in the same area (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing: (a) a procedure of the hip joint by arthroscopic means; or (b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)	$1,589.50
49372	Revision arthroplasty of hip, with exchange of head or liner (or both) (H) (Anaes.) (Assist.)	$2,098.40
49374	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	$3,897.20
49376	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including major bone grafting (if performed) (H) (Anaes.) (Assist.)	$4,796.70
49378	Revision arthroplasty of hip, with revision of femoral component (if there is no requirement for femoral osteotomy), including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	$4,196.80
49380	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	$5,096.50
49382	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including major bone grafting (H) (Anaes.) (Assist.)	$6,595.30
49384	Revision arthroplasty of hip, for pelvic discontinuity, with revision of acetabular component (H) (Anaes.) (Assist.)	$7,794.40
49386	Revision arthroplasty of hip, with revision of femoral component with femoral osteotomy, including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	$5,396.10
49388	Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) minor bone grafting (if performed) (H) (Anaes.) (Assist.)	$6,295.80
49390	Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) major bone grafting (H) (Anaes.) (Assist.)	$7,494.70
49392	Revision arthroplasty of hip, including: (a) either: (i) revision of femoral component with femoral osteotomy; or (ii) proximal femoral replacement; and (b) revision of acetabular component for pelvic discontinuity (H) (Anaes.) (Assist.)	$10,492.50
49394	Revision arthroplasty of hip, including: (a) replacement of proximal femur; and (b) revision of the acetabular component; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.)	$8,993.60
49396	Revision arthroplasty of hip, including: (a) removal of prosthesis as stage 1 of a 2-stage revision arthroplasty or as a definitive stage procedure; and (b) insertion of temporary prosthesis (if performed) (H) (Anaes.) (Assist.)	$5,995.70
49398	Revision arthroplasty of hip, including: (a) revision of femoral component for periprosthetic fracture; and (b) internal fixation; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.)	$4,497.00
49500	Knee, arthrotomy of, involving one or more of capsular release, biopsy or lavage, or removal of loose body or foreign body (H) (Anaes.) (Assist.)	$895.60
49503	Arthrotomy of knee, including one of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,097.90
49506	Arthrotomy of knee, including 2 or more of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,749.50
49509	Total synovectomy of knee, by open procedure, other than a service performed in association with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroplasty (H) (Anaes.) (Assist.)	$1,682.40
49512	Primary or revision arthrodesis of knee, including arthrodesis (H) (Anaes.) (Assist.)	$2,955.80
49515	Removal of cemented or uncemented knee prosthesis, performed as the first stage of a 2-stage procedure; including: (a) removal of associated cement; and (b) insertion of spacer (if required) (H) (Anaes.) (Assist.)	$1,923.30

Item No.	Description	Max Fee (excl. GST)
49516	Bilateral unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.)	$4,802.50
49517	Unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.)	$2,753.80
49518	Total arthroplasty of knee, including either or both of the following (if performed): (a) revision of patello-femoral joint replacement to total knee replacement; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$3,147.00
49519	Bilateral total arthroplasty of knee, including patellar resurfacing, other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$5,397.40
49521	Complex primary arthroplasty of knee, using revision femoral or tibial components, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$3,798.40
49524	Complex primary arthroplasty of knee: (a) using revision femoral and tibial components; or (b) using revision femoral or tibial components including anatomic specific allograft of femur or tibia; including either or both of the following (if performed): (c) ligament reconstruction; (d) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$4,472.60
49525	Revision of uni-compartmental arthroplasty of the knee, with femoral or tibial components (or both) with uni-compartmental implants, other than a service associated with a service to which: (a) item 48245, 48248, 48251, 48254 or 48257 applies; or (b) another item in this Group applies if the service described in the other item is for the purpose of performing surgery on a knee (H) (Anaes.) (Assist.)	$3,641.30
49527	Minor revision of total or partial arthroplasty of knee, including either or both of the following: (a) exchange of polyethylene component (including uni); (b) insertion of patellar component; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$3,253.20
49530	Revision of total or partial arthroplasty of knee, with exchange of femoral or tibial component: (a) excluding revision of unicompartmental with unicompartmental implants; and (b) including patellar resurfacing (if performed); other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$4,418.50
49533	Revision of total or partial arthroplasty of knee, with exchange of femoral and tibial components, excluding revision of unicompartmental with unicompartmental implants, including patellar resurfacing (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$6,136.50
49534	Arthroplasty of patella and trochlea of patello-femoral joint of knee, performed as a primary procedure (H) (Anaes.) (Assist.)	$1,614.30
49536	Either: (a) repair of cruciate ligaments of knee; or (b) repair or reconstruction of collateral ligaments of knee; by open or arthroscopic means, including either or both of the following (if performed): (c) graft harvest; (d) intraarticular knee surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	$2,143.40
49542	Reconstruction of anterior or posterior cruciate ligament of knee, by open or arthroscopic means, including any of the following (if performed): (a) graft harvest; (b) donor site repair; (c) meniscal repair; (d) collateral ligament repair; (e) extra-articular tenodesis; (f) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	$2,960.80
49544	Reconstruction of 2 or more cruciate or collateral ligaments of knee, by open or arthroscopic means, including any of the following (if performed): (a) ligament repair; (b) graft harvest donor site repair; (c) meniscal repair; (d) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	$3,490.30
49548	Knee, revision of patello-femoral stabilisation (H) (Anaes.) (Assist.)	$2,225.70
49551	Knee, revision of procedures to which item 49536 or 49542 applies (H) (Anaes.) (Assist.)	$2,959.40
49554	Revision of total replacement of knee, by anatomic specific allograft of tibia or femur, other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	$4,473.30
49564	Stabilisation of patellofemoral joint of knee, by combined open and arthroscopic means, including either or both of the following (if performed): (a) medial soft tissue reconstruction and tendon transfer; (b) tibial tuberosity transfer with bone graft and internal fixation; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	$2,200.60
49565	Reconstruction of patellofemoral joint of knee, by combined open and arthroscopic means, including: (a) both of the following: (i) medial soft tissue reconstruction; (ii) tibial tuberosity transfer; and (b) any of the following (if performed): (i) bone graft; (ii) internal fixation; (iii) trochleoplasty; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	$3,001.00

Item No.	Description	Max Fee (excl. GST)
49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (H) (Anaes.) (Assist.)	$1,794.60
49570	Diagnosis of knee, by arthroscopic means, when the pre-procedure diagnosis is undetermined, including either or both of the following (if performed): (a) biopsy; (b) lavage (H) (Anaes.) (Assist.)	$621.00
49572	Partial meniscectomy of knee, by arthroscopic means, for atraumatic meniscus tear, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating osteoarthritis (H) (Anaes.) (Assist.)	$1,511.10
49574	Removal of loose bodies of knee, by arthroscopic means one or more bodies (H) (Anaes.) (Assist.)	$1,511.10
49576	Repair of chondral lesion of knee, by arthroscopic means, including either or both of the following (if performed): (a) microfracture; (b) microdrilling; other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing chondral or osteochondral grafts (H) (Anaes.) (Assist.)	$1,511.10
49578	Release of soft tissue, lateral release or osteoplasty of knee, by arthroscopic means, other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of stabilising the patellofemoral joint of the knee (H) (Anaes.) (Assist.)	$1,511.10
49580	Partial meniscectomy of knee, by arthroscopic means, for traumatic meniscus tear (H) (Anaes.) (Assist.)	$1,511.10
49582	Meniscal repair of knee, by arthroscopic means (H) (Anaes.) (Assist.)	$1,764.40
49584	Chondral, osteochondral or meniscal graft of knee, by arthroscopic means (H) (Anaes.) (Assist.)	$1,764.40
49586	Synovectomy of knee, by arthroscopic means, for neoplasia or inflammatory arthropathy, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating uncomplicated osteoarthritis (H) (Anaes.) (Assist.)	$1,764.40
49590	Excision of ganglion, cyst or bursa of knee, by open or arthroscopic means, performed as an independent procedure, other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$845.20
49592	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the hip, including pelvis and proximal femur (H) (Anaes.) (Assist.)	$2,175.10
49594	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the knee, including distal femur, proximal fibula and proximal tibia (H) (Anaes.) (Assist.)	$1,740.00
49596	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the lower leg, other than a service to which item 49594 applies (H) (Anaes.) (Assist.)	$1,305.10
49703	Surgery of ankle joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means (H) (Anaes.) (Assist.)	$1,397.50
49706	Arthrotomy of joint of ankle, including removal of loose bodies and joint debridement, including release of joint contracture (if performed) (H) (Anaes.) (Assist.)	$734.70
49709	Stabilisation of ligament of ankle or subtalar joint (or both), including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) joint debridement; one ligament complex, each incision (H) (Anaes.) (Assist.)	$1,588.30
49712	Arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	$2,265.70
49715	Total replacement of ankle, with prosthetic replacement of ankle joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	$2,613.30
49716	Revision of total ankle replacement: (a) including either: (i) exchange of tibial or talar components (or both) or plastic inserts; or (ii) removal of tibial or talar components (or both) and plastic inserts; and (b) including any of the following (if performed): (i) insertion of cement spacer for infection; (ii) capsulotomy; (iii) joint release; (iv) neurolysis; (v) debridement of cysts; (vi) synovectomy; (vii) joint debridement other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	$3,514.70
49717	Revision of total ankle replacement: (a) including either: (i) exchange of tibial and talar components; or (ii) removal of tibial and talar components and conversion to ankle arthrodesis; and (b) including both of the following (iii) internal or external fixation, by any means; (iv) major bone grafting; and (c) including any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and extensive grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023, 48245, 48248, 48251, 48254 or 48257 applies that is performed at the same site (H) (Anaes.) (Assist.)	$3,998.70
49718	Primary repair of major tendon of ankle, by any method, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy one tendon (H) (Anaes.) (Assist.)	$869.50

Item No.	Description	Max Fee (excl. GST)
49724	Reconstruction of major tendon of ankle, by any method, including any of the following (if performed): (a) synovial biopsy; (b) synovectomy; (c) adjacent tendon transfer; (d) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.)	$1,736.10
49727	Lengthening of major tendon of ankle, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy (H) (Anaes.) (Assist.)	$661.70
49728	Lengthening of Achilles tendon, by any method, with gastro-soleus lengthening for the correction of equinous deformity, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; other than a service associated with a service to which item 49727 applies (H) (Anaes.) (Assist.)	$1,270.40
49730	Surgery of joint of hindfoot (other than ankle) or first metatarsophalangeal joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means one joint (H) (Anaes.) (Assist.)	$1,392.10
49732	Endoscopy of large tendons of foot, including any of the following (if performed): (a) debridement of tendon and sheath; (b) removal of loose bodies; (c) synovectomy; (d) excision of tendon impingement; other than a service associated with a service to which item 49718 or 49724 applies (H) (Anaes.) (Assist.)	$1,392.10
49734	Arthrotomy of hindfoot, midfoot or metatarsophalangeal joint, including: (a) removal of loose bodies; and (b) either or both of the following: (i) joint debridement; (ii) release of joint contracture; each incision (H) (Anaes.) (Assist.)	$749.60
49736	Transfer of major tendon of foot and ankle, including: (a) split or whole transfer to contralateral side of foot; and (b) passage of posterior or anterior tendon to, or through, interosseous membrane; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy; (iii) tendon lengthening; (iv) insetting of tendon (H) (Anaes.) (Assist.)	$1,499.40
49738	Stabilisation of ligament of talonavicular or metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement (H) (Anaes.) (Assist.)	$1,070.70
49740	Revision of arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$3,212.80
49742	Arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	$3,032.90
49744	Revision of arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$4,549.40
49760	Arthroereisis of subtalar joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)	$803.10
49761	Stabilisation of metatarsophalangeal joint at metatarsal, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; one metatarsal (H) (Anaes.) (Assist.)	$1,178.00
49762	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 2 metatarsals (H) (Anaes.) (Assist.)	$1,438.00
49763	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 3 metatarsals (H) (Anaes.) (Assist.)	$1,580.20
49764	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 4 metatarsals (H) (Anaes.) (Assist.)	$1,722.40
49765	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 5 metatarsals (H) (Anaes.) (Assist.)	$1,864.50
49766	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 6 metatarsals (H) (Anaes.) (Assist.)	$2,006.90

Item No.	Description	Max Fee (excl. GST)
49767	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 7 metatarsals (H) (Anaes.) (Assist.)	$2,149.00
49768	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 8 metatarsals (H) (Anaes.) (Assist.)	$2,291.10
49769	Unilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$2,061.40
49770	Bilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$3,426.30
49771	Synovectomy of major tendon of ankle, for extensive synovitis by any method, including any of the following (if performed): (a) tenolysis; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercule or osteophyte; (e) reconstruction of tendon retinaculum; (f) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.)	$845.20
49772	Excision of rheumatoid nodules or gouty tophi, excluding aftercare, including any of the following (if performed): (a) capsulotomy; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercle or osteophyte; each incision (H) (Anaes.) (Assist.)	$745.80
49773	Revision of excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of tissues; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one web space (H) (Anaes.) (Assist.)	$924.40
49774	Release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one foot (H) (Anaes.) (Assist.)	$629.60
49775	Revision of release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one foot (H) (Anaes.) (Assist.)	$850.10
49776	Revision of arthrodesis of joint of hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site may only be claimed once per joint (H) (Anaes.) (Assist.)	$2,673.90
49777	Arthrodesis of joint of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; one joint (H) (Anaes.) (Assist.)	$1,583.20
49778	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; 2 joints (H) (Anaes.) (Assist.)	$2,374.90
49779	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; 3 joints (H) (Anaes.) (Assist.)	$2,770.60
49780	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; 4 joints (H) (Anaes.) (Assist.)	$3,166.50
49781	Revision of arthrodesis of joint of midfoot, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of ostephytes at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion; one joint (H) (Anaes.) (Assist.)	$2,374.90
49782	Revision of total ankle replacement, including: (a) bone grafting of perioperative cysts to the tibia or talus (or both); and (b) retention of implants; and (c) any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	$1,286.30
49783	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 3 joints (H) (Anaes.) (Assist.)	$1,725.00
49784	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 4 joints (H) (Anaes.) (Assist.)	$1,971.20

Item No.	Description	Max Fee (excl. GST)
49785	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 5 joints (H) (Anaes.) (Assist.)	$2,217.50
49786	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 6 joints (H) (Anaes.) (Assist.)	$2,463.70
49787	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 7 joints (H) (Anaes.) (Assist.)	$2,709.90
49788	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 8 joints (H) (Anaes.) (Assist.)	$2,956.20
49789	Bilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	$2,542.80
49790	Revision of arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of exostosis at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion (H) (Anaes.) (Assist.)	$2,208.70
49791	Arthrodesis of hallux interphalangeal or lesser metatarsophalangeal joint, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	$1,001.40
49792	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; one or 2 toes (H) (Anaes.) (Assist.)	$1,124.70
49793	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 3 toes (H) (Anaes.) (Assist.)	$1,312.20
49794	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 4 toes (H) (Anaes.) (Assist.)	$1,499.50
49795	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 5 toes (H) (Anaes.) (Assist.)	$1,687.10
49796	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 6 toes (H) (Anaes.) (Assist.)	$1,874.60
49797	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 7 toes (H) (Anaes.) (Assist.)	$2,061.90
49798	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 8 toes (H) (Anaes.) (Assist.)	$2,249.50
49800	Primary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; one toe (H) (Anaes.) (Assist.)	$310.20
49803	Secondary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; one toe (H) (Anaes.) (Assist.)	$410.80
49806	Subcutaneous tenotomy of foot, by small percutaneous incisions one or more tendons (Anaes.)	$311.10
49809	Open tenotomy or lengthening of foot, by open incision, with or without tenoplasty, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; one toe (H) (Anaes.) (Assist.)	$500.50
49812	Advancement of tendon or ligament transfer of foot, including: (a) side to side transfer, harvesting and transfer for ligament or minor foot tendon reconstruction; and (b) either or both of the following (if performed): (i) synovial biopsy; (ii) synovectomy; one major tendon or toe (H) (Anaes.) (Assist.)	$1,035.20
49814	Reconstruction of major tendon of ankle, by any method, including: (a) osteotomy of hindfoot, with internal fixation; and (b) lengthening of major tendon of ankle; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy; (iii) adjacent tendon transfer; (iv) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.)	$2,249.10
49815	Triple arthrodesis of hindfoot joints, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.)	$2,356.40
49818	Release of plantar fascia, including excision of calcaneal spur (if performed) (H) (Anaes.) (Assist.)	$686.80

Item No.	Description	Max Fee (excl. GST)
49821	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement one joint (H) (Anaes.) (Assist.)	$987.20
49824	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 2 joints (H) (Anaes.) (Assist.)	$1,692.60
49827	Unilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$1,094.50
49830	Bilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$1,897.60
49833	Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$1,250.50
49836	Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$2,089.90
49837	Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, with internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$1,466.30
49838	Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, with internal fixation or arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	$2,504.60
49839	Total replacement of first metatarsophalangeal joint, with replacement of both joint surfaces, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)	$1,192.20
49845	Unilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.)	$1,472.50
49851	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal (or both) joints of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) tendon lengthening; (d) joint release; (e) synovectomy; (f) removal of osteophytes at joints; one toe (H) (Anaes.) (Assist.)	$662.00
49854	Radical plantar fasciotomy or fasciectomy, with extensive incision into foot and excision of fascia, including excision of calcaneal spur (if performed), other than a service associated with a service to which 49818 applies (H) (Anaes.) (Assist.)	$893.20
49857	Hemi joint replacement of first or lesser metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)	$879.50
49860	Synovectomy of metatarsophalangeal joints, including any of the following (if performed): (a) capsulotomy; (b) debridement; (c) release of ligament or tendon (or both); one or more joints on one foot (H) (Anaes.) (Assist.)	$749.10
49866	Excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of metatarsal or digital ligament; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one web space (H) (Anaes.) (Assist.)	$688.50
49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation each attendance (Anaes.)	$135.20
49881	Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any local method; other than a service associated with a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.)	$500.40
49884	Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.)	$845.20
49887	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any method; other than a service associated with: (c) a service to which item 49881 applies; or (d) a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.)	$675.60

Item No.	Description	Max Fee (excl. GST)
49890	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindfoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with: (c) a service to which item 49884 applies; or (d) a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.)	$1,140.80
50107	Stabilisation of joint of hip, by open means, including any of the following (if performed): (a) repair of capsule; (b) labrum; (c) capsulorraphy; (d) repair of ligament; (e) internal fixation; other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,070.70
50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$863.20
50115	Manipulation of one or more joints, excluding spine, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$339.20
50118	Arthrodesis of joint of hindfoot, by any method, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; one joint (H) (Anaes.) (Assist.)	$1,320.20
50130	Joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.)	$766.90
50200	Core needle biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.)	$450.90
50201	Incisional biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.) (Assist.)	$759.60
50203	Intralesional or marginal excision of bone or soft tissue tumour (H) (Anaes.) (Assist.)	$986.60
50206	Intralesional or marginal excision of bone tumour, with at least one of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.)	$1,405.90
50209	Intralesional or marginal excision of bone tumour, with at least 2 of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.)	$1,795.20
50212	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), affecting a limb, trunk or scapula (H) (Anaes.) (Assist.)	$3,912.60
50215	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with intercalary reconstruction of bone by prosthesis, allograft or autograft (H) (Anaes.) (Assist.)	$4,913.80
50218	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with reconstruction, replacement or arthrodesis of adjacent joint, by prosthesis, allograft or autograft (H) (Anaes.) (Assist.)	$6,529.50
50221	Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, without reconstruction (H) (Anaes.) (Assist.)	$6,048.60
50224	Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, with reconstruction of bone defect, or one or more joints, by any technique (H) (Anaes.) (Assist.)	$6,727.90
50233	Treatment of malignant or aggressive bone or soft tissue tumour (or both) by hindquarter or forequarter amputation (H) (Anaes.) (Assist.)	$5,141.40
50236	Treatment of malignant or aggressive bone or soft tissue tumour (or both), by hip disarticulation, shoulder disarticulation or amputation through the proximal one third of the femur (H) (Anaes.) (Assist.)	$3,988.40
50239	Treatment of malignant or aggressive bone or soft tissue tumour (or both), by amputation, other than a service associated with a service to which item 50233 or 50236 applies (H) (Anaes.) (Assist.)	$2,687.40
50242	Revision of endoprosthetic replacement, if item 50218 or 50224, or an item that describes a service substantially similar to either of those items, applied to the initial procedure: (a) including any of the following: (i) rebushing; (ii) patella resurfacing; (iii) polyethylene exchange or similar; and (b) excluding removal of prosthetic from bone (H) (Anaes.) (Assist.)	$1,927.50
50245	Revision of reconstructive procedure, if item 50215, 50218 or 50224, or an item that describes a service substantially similar to any of those items, applied to the initial procedure, by any technique or combination of techniques (H) (Anaes.) (Assist.)	$5,782.80
50300	Gradual correction of joint deformity, with application of external fixator (H) (Anaes.) (Assist.)	$2,754.40
50303	Limb lengthening, by gradual distraction, with application of external fixator or intra-medullary device (H) (Anaes.) (Assist.)	$3,766.00
50306	Bipolar limb lengthening: (a) with application of external fixator or intra-medullary device; and (b) by any of the following: (i) gradual distraction; (ii) bone transport; (iii) fixator extension, to correct for an adjacent joint deformity (H) (Anaes.) (Assist.)	$5,875.90
50309	Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia, other than a service to which item 50303 or 50306 applies (H) (Anaes.) (Assist.)	$723.60

Item No.	Description	Max Fee (excl. GST)
50310	Major adjustment of ring fixator or similar device, other than a service associated with a service to which item 50303, 50306, or 50309 applies	$99.30
50312	Synovectomy or debridement, and microfracture, of ankle joint for osteochondral large defect greater than 1.5cm^2, by arthroscopic or open means, including any of the following (if performed): (a) capsulotomy; (b) debridement or release of ligament; (c) debridement or release of tendon; other than a service associated with a service to which any of the following apply: (d) item 49703; (e) another item in this Schedule if the service described in the other item is for the purpose of performing an arthroscopic procedure of the ankle (H) (Anaes.) (Assist.)	$1,734.40
50321	Release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.)	$2,219.90
50324	Revision of release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.)	$3,100.40
50330	Post operative manipulation, and change of plaster, of vertical, congenital talipes equinovarus or talus, other than a service to which item 50321 or 50324 applies (H) (Anaes.)	$528.70
50333	Excision of tarsal coalition, with interposition of muscle, fat graft or similar graft, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) excision of osteophytes; one coalition (H) (Anaes.) (Assist.)	$1,426.80
50335	Treatment of vertical, congenital talus, by percutaneous or open stabilisation of talonavicular joint and Achilles tenotomy (H) (Anaes.) (Assist.)	$1,403.20
50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (H) (Anaes.) (Assist.)	$2,159.10
50339	Tibialis anterior or tibialis posterior tendon transfer (split or whole) (H) (Anaes.) (Assist.)	$1,392.40
50345	Hyperextension deformity of toe, release incorporating V Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (H) (Anaes.) (Assist.)	$774.10
50348	Knee, deformity of, post operative manipulation and change of plaster, performed under general anaesthesia (H) (Anaes.)	$543.00
50351	Treatment of developmental dislocation of hip, by open reduction, including application of hip spica (H) (Anaes.) (Assist.)	$3,740.00
50352	Treatment of developmental dysplasia of hip, including supervision of initial application of splint, harness or cast, other than a service to which another item in this Group applies (Anaes.)	$135.20
50354	Resection and fixation of congenital pseudarthrosis of tibia (H) (Anaes.) (Assist.)	$3,067.50
50357	Transfer of tendon of rectus femoris or medial or lateral hamstring (H) (Anaes.) (Assist.)	$1,303.10
50360	Combined medial and lateral hamstring tendon transfer (H) (Anaes.) (Assist.)	$1,448.10
50369	Unilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.)	$1,453.70
50372	Bilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.)	$2,678.40
50375	Unilateral medial release of hip contracture, with lengthening or division of the adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.)	$1,211.60
50378	Bilateral medial release of hip contracture, with lengthening or division of adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.)	$2,035.50
50381	Unilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.)	$1,547.30
50384	Bilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.)	$2,740.40
50390	Application of cast under general anaesthesia, for patient with perthes, cerebral palsy, or other neuromuscular conditions, affecting hips or knees (H) (Anaes.)	$511.20
50393	Acetabular shelf procedure, other than a service associated with a service to which another item of this Schedule applies if the service in the other item is for the purpose of performing arthroplasty on the hip (H) (Anaes.) (Assist.)	$2,013.10
50394	Multiple peri-acetabular osteotomy, including internal fixation (if performed) (H) (Anaes.) (Assist.)	$6,197.00
50395	Osteotomy and distillation of greater trochanter, with internal fixation (H) (Anaes.) (Assist.)	$2,077.50

Item No.	Description	Max Fee (excl. GST)
50396	Amputation of congenital abnormalities or duplication of digits of the hand or foot, including any of the following (if performed): (a) splitting of phalanx or phalanges; (b) ligament reconstruction; (c) joint reconstruction (H) (Anaes.) (Assist.)	$1,054.70
50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (H) (Anaes.) (Assist.)	$2,159.10
50411	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (H) (Anaes.) (Assist.)	$3,067.50
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 (H) (Anaes.) (Assist.)	$4,138.90
50417	Lower limb deficiency, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (H) (Anaes.) (Assist.)	$3,067.50
50420	Patella, congenital dislocation of, reconstruction of the quadriceps (H) (Anaes.) (Assist.)	$2,532.40
50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (H) (Anaes.) (Assist.)	$2,397.90
50426	Removal of one or more lesions from bone, for osteochondroma occurring solitary or in association with hereditary multiple exotoses, with histological examination one approach (H) (Anaes.) (Assist.)	$1,035.00
50428	Percutaneous drilling of osteochondritis dessicans or other osteochondral lesion, for a patient: (a) with open growth plates; or (b) less than 18 years of age (H) (Anaes.) (Assist.)	$1,764.40
50450	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	$2,858.40
50451	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	$2,858.40
50455	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	$3,237.00
50456	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	$3,237.00
50460	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	$4,832.50
50461	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	$4,832.50
50465	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	$6,806.80

Item No.	Description	Max Fee (excl. GST)
50466	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	$6,806.80
50470	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	$8,632.60
50471	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	$8,632.60
50475	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait, including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	$9,961.10
50476	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	$9,961.10
50508	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, for a patient with open growth plates (Anaes.)	$883.60
50512	Treatment of fracture of distal end of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plates (H) (Anaes.) (Assist.)	$1,254.80
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 (H) (Anaes.) (Assist.)	$956.50
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 (H) (Anaes.) (Assist.)	$1,650.70
50532	Treatment of fracture of shafts of radius or ulna (or both), by closed reduction, for a patient with open growth plate (H) (Anaes.)	$1,720.40
50536	Treatment of fracture of shafts of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	$1,707.80
50540	Olecranon, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	$1,257.80
50544	Radius, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (H) (Anaes.)	$617.10
50548	Radius, with open growth plate, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	$1,234.90
50552	Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.)	$1,081.00
50556	Treatment of fracture of proximal humerus, by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	$1,438.50
50560	Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.)	$1,110.90

Item No.	Description	Max Fee (excl. GST)
50564	Treatment of fracture of shaft of humerus, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	$1,481.30
50568	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)	$1,321.00
50572	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	$1,755.60
50576	Treatment of fracture of femur, by closed reduction or traction, including application of hip spica (if performed), for a patient with open growth plate (H) (Anaes.) (Assist.)	$1,609.00
50580	Tibia, with open growth plate, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	$1,491.00
50584	Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	$1,445.00
50588	Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.)	$1,882.50
50592	Treatment of fracture of shaft of femur, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	$2,184.40
50596	Treatment of fracture of shaft of tibia, by open or closed reduction, including casting, for a patient with open growth plate (H) (Anaes.) (Assist.)	$683.00
50600	Scoliosis or kyphosis, in a child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (H) (Anaes.) (Assist.)	$1,012.60
50604	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.)	$4,298.50
50608	Scoliosis or kyphosis, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	$8,072.30
50612	Scoliosis or kyphosis, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	$11,566.90
50616	Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (H) (Anaes.) (Assist.)	$1,469.60
50620	Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, involving more than one of osteotomy, fusion, removal of instrumentation or instrumentation, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	$8,177.50
50624	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (H) (Anaes.) (Assist.)	$7,655.70
50628	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) more than 4 levels (H) (Anaes.) (Assist.)	$10,035.90
50632	Scoliosis or kyphosis, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	$8,450.30
50636	Scoliosis, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	$9,212.00
50640	Scoliosis, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	$5,092.20
50644	Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (H) (Anaes.) (Assist.)	$4,887.20
50654	Examination or closed reduction (or both) of hip under anaesthesia for a patient under the age of 18 years, including any of the following (if performed): (a) diagnostic injection; (b) arthrography; (c) application or reapplication of a hip spica (H) (Anaes.) (Assist.)	$1,157.00
	Radiofrequency ablation	
50950	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (H) (Anaes.)	$1,859.50
50952	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic ablation (including any associated imaging services), if a multi disciplinary team has assessed that percutaneous ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved; (b) vital organs or tissues are at risk of damage from the percutaneous ablation procedure; (c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for ablation; other than a service associated with a service to which item 30419 or 50950 applies (H) (Anaes.)	$1,948.30

Item No.	Description	Max Fee (excl. GST)
	Spinal Surgery	
51011	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	$3,127.40
51012	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	$4,170.00
51013	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (H) (Anaes.) (Assist.)	$5,212.50
51014	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (H) (Anaes.) (Assist.)	$6,255.20
51015	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (H) (Anaes.) (Assist.)	$7,297.50
51020	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spinous process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a service associated with: (a) interspinous dynamic stabilisation devices; or (b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)	$1,667.90
51021	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	$2,791.50
51022	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	$3,472.50
51023	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	$4,132.60
51024	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 5 or 6 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (H) (Anaes.) (Assist.)	$4,770.90
51025	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 7 to 12 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (H) (Anaes.) (Assist.)	$5,576.20
51026	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, more than 12 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (H) (Anaes.) (Assist.)	$6,105.20
51031	Spine, posterior and/or posterolateral bone graft to, one motion segment, not being a service associated with a service to which item 51032, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	$2,051.20
51032	Spine, posterior and/or posterolateral bone graft to, 2 motion segments, not being a service associated with a service to which item 51031, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	$2,461.50
51033	Spine, posterior and/or posterolateral bone graft to, 3 motion segments, not being a service associated with a service to which item 51031, 51032, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	$2,872.10
51034	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51035 or 51036 applies (Anaes.) (Assist.)	$3,077.10
51035	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51036 applies (Anaes.) (Assist.)	$3,282.20
51036	Spine, posterior and/or posterolateral bone graft to, 12 or more motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51035 applies (Anaes.) (Assist.)	$3,487.40
51041	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), one motion segment, not being a service associated with a service to which item 51042, 51043, 51044 or 51045 applies (Anaes.) (Assist.)	$2,359.10
51042	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 2 motion segments, not being a service associated with a service to which item 51041, 51043, 51044 or 51045 applies (Anaes.) (Assist.)	$3,302.90
51043	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 3 motion segments, not being a service associated with a service to which item 51041, 51042, 51044 or 51045 applies (Anaes.) (Assist.)	$4,128.40

Item No.	Description	Max Fee (excl. GST)
51044	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 4 motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51045 applies (Anaes.) (Assist.)	$4,482.30
51045	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 5 or more motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51044 applies (Anaes.) (Assist.)	$4,718.20
51051	Pedicle subtraction osteotomy, one vertebra, not being a service associated with a service to which item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$4,030.90
51052	Pedicle subtraction osteotomy, 2 vertebrae, not being a service associated with a service to which item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$4,902.60
51053	Vertebral column resection osteotomy performed through single posterior approach, one vertebra, not being a service associated with a service to which item 51051, 51052, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$5,578.20
51054	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$2,974.20
51055	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$4,461.40
51056	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$5,204.80
51057	Vertebral body, en bloc excision of (complete spondylectomy), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51058 or 51059 applies (Anaes.) (Assist.)	$5,229.40
51058	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51059 applies (Anaes.) (Assist.)	$5,884.30
51059	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anaes.) (Assist.)	$7,190.50
51061	Spinal fusion, anterior and posterior, including spinal instrumentation at one motion segment, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)	$6,176.50
51062	Spinal fusion, anterior and posterior, including spinal instrumentation at 2 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)	$8,006.10
51063	Spinal fusion, anterior and posterior, including spinal instrumentation at 3 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51064, 51065 or 51066 applies (Anaes.) (Assist.)	$9,696.90
51064	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51065 or 51066 applies (Anaes.) (Assist.)	$1,0791.90
51065	Spinal fusion, anterior and posterior, including spinal instrumentation at 8 to 11 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51066 applies (Anaes.) (Assist.)	$11,935.70
51066	Spinal fusion, anterior and posterior, including spinal instrumentation at 12 or more motion segments, posterior and/or posterolateral bone graft, and anterior column fusion not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51065 applies (Anaes.) (Assist.)	$12,567.00
51071	Removal of intradural lesion, or primary extradural tumour or lesion, where the pathology is confirmed by histology - not including removal of synovial or juxtafacet cyst and not being a service associated with a service to which item 51072 or 51073 applies (H) (Anaes.) (Assist.)	$5,447.20
51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.)	$5,665.10
51073	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with a service to which item 51071 or 51072 applies (Anaes.) (Assist.)	$7,190.50
51102	Thoracoplasty in combination with thoracic scoliosis correction 3 or more ribs (Anaes.) (Assist.)	$2,578.50
51103	Odontoid screw fixation (Anaes.) (Assist.)	$4,531.60

Item No.	Description	Max Fee (excl. GST)
51110	Spine, treatment of fracture, dislocation or fracture dislocation, with immobilisation by calipers or halo, not including application of skull tongs or calipers as part of operative positioning (H) (Anaes.)	$1,641.40
51111	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)	$697.60
51112	Plaster jacket, application of, as an independent procedure (Anaes.)	$471.80
51113	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)	$523.10
51114	Halo thoracic orthosis application of both halo and thoracic jacket (Anaes.)	$923.20
51115	Halo femoral traction, as an independent procedure (H) (Anaes.)	$923.20
51120	Bone graft, harvesting of autogenous graft, via separate incision or via subcutaneous approach, in conjunction with spinal fusion, other than for the purposes of bone graft obtained from the cervical, thoracic, lumbar or sacral spine (Anaes.)	$513.30
51130	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes: (a) for a patient who: (i) has not had prior spinal fusion surgery at the same lumbar level; and (ii) does not have vertebral osteoporosis; and (iii) has failed conservative therapy; and (b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.)	$3,908.30
51131	Cervical artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy (Anaes.) (Assist.)	$2,359.10
51140	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation up to 3 motion segments, not being a service associated with a service to which item 51141 applies (Anaes.) (Assist.)	$963.90
51141	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation more than 3 motion segments, not being a service associated with a service to which item 51140 applies (Anaes.) (Assist.)	$1,783.50
51145	Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.)	$963.90
51150	Coccyx, excision of (Anaes.) (Assist.)	$970.40
51160	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (Anaes.) (Assist.)	$2,505.60
51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, excluding vertebral body tethering for the treatment of scoliosis and not being a service to which item 51160 applies (H) (Anaes.) (Assist.)	$3,159.50
51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.)	$4,759.90
51171	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.)	$1,999.00
	Ear, nose and throat	
41527	Myringoplasty, by trans-canal approach, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$1,310.90
41530	Myringoplasty, post-aural or endaural approach, with or without mastoid inspection, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.)	$2,291.90
41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$2,713.10
41536	Atticotomy with reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$3,061.30
41545	Mastoidectomy (cortical), other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$1,163.20
41551	Mastoidectomy, intact wall technique, with myringoplasty, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$3,793.20
41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which item 41603 or another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$4,393.90
41557	Mastoidectomy (radical or modified radical), other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$2,465.50
41560	Mastoidectomy (radical or modified radical) and myringoplasty, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.)	$2,670.10

Item No.	Description	Max Fee (excl. GST)
41563	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$3,410.20
41564	Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$4,265.00
41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$2,590.30
41629	Middle ear, exploration of, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$1,164.60
41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$2,553.50
41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty with ossicular chain reconstruction, other than a service associated with a service to which another item in this Subgroup applies on the same side (H) (Anaes.) (Assist.)	$3,398.20
41671	Septal surgery, including septoplasty, septal reconstruction, septectomy, closure of septal perforation or other modifications of the septum, not including cauterisation, by any approach, other than a service associated with a service to which item 41689, 41692 or 41693 applies (H) (Anaes.) (Assist.)	$1,229.30
41689	Turbinate reduction, partial or total, unilateral or bilateral, other than a service associated with a service to which item 41671, 41692 or 41693 applies (Anaes.)	$335.80
41692	Turbinate, submucous resection with removal of bone, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689 or 41693 applies (H) (Anaes.)	$456.30
41693	Septal surgery with submucous resection of turbinates, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689, 41692 or 41764 applies (H) (Anaes.) (Assist.)	$1,541.60
41702	Functional sinus surgery of the ostiomeatal unit, including ethmoid, unilateral, other than a service associated with a service to which item 41662, 41698, 41703, 41705, 41710 or 41764 applies on the same side (H) (Anaes.) (Assist.)	$1,371.50
41703	Functional sinus surgery, complete dissection of all 5 sinuses and creation of single sinus cavity, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41705, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.)	$2,027.60
41705	Functional sinus surgery, complete dissection of all 5 sinuses to create a single sinus cavity, with extended drilling of frontal sinuses, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41703, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.)	$3,299.10
41710	Antrostomy by any approach, other than a service associated with a service to which item 41702, 41703, 41705 or 41698 applies on the same side (H) (Anaes.) (Assist.)	$1,114.70
41734	Endoscopic Lothrop procedure or radical external frontal sinusotomy with osteoplastic flap, unilateral, other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side (H) (Anaes.) (Assist.)	$2,262.40
41737	Frontal sinus, unilateral, intranasal operation on, including complete dissection of frontal recess and exposure of frontal sinus ostium (excludes simple probing, dilatation or irrigation of frontal sinus), other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side (H) (Anaes.) (Assist.)	$1,157.70
41752	Sphenoidal sinus, unilateral, intranasal operation on, other than a service associated with a service to which item 41703 or 41705 applies on the same side (H) (Anaes.) (Assist.)	$707.60
GROUP T9—ASSISTANCE AT OPERATIONS		
51300	NOTE: Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner. Assistance at any operation identified by the word Assist for which the fee does not exceed $1,196.80 or at a series or combination of operations identified by the word Assist where the fee for the series or combination of operations identified by the word Assist does not exceed $1,196.80.	$196.50
51303	Assistance at any operation identified by the word Assist for which the fee exceeds $1,196.80 or at a series of operations identified by the word Assist for which the aggregate fee exceeds $1,196.80. Derived fee: One fifth of the established fee for the operation or combination of operations.	DF
51306	Assistance at a birth involving Caesarean section (H)	$281.30
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 (H) 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

Item No.	Description	Max Fee (excl. GST)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627 (H) 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 (H)	$640.80
51318	Assistance at cataract and intraocular lens surgery, if patient has: (a) total loss of vision, including no potential for central vision, in the fellow eye; or (b) one of the following in the fellow eye: (i) vitreous loss; (ii) rupture of posterior capsule; (iii) loss of nuclear material into the vitreous; (iv) intraocular haemorrhage; (v) intraocular infection (endophthalmitis); (vi) cystoid macular oedema; (vii) corneal decompensation; (viii) retinal detachment; or (c) 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 (H)	$427.40
GROUP O1—CONSULTATIONS		
51700	APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her	$238.50
51703	Professional attendance by an approved dental practitioner, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her	$120.10
GROUP O2—ASSISTANCE OF OPERATIONS		
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation mentioned in an item that includes (Assist.) for which the fee does not exceed $1,196.80 or at a series or combination of operations mentioned in an item in Groups O3 to O9 that include (Assist.) for which the aggregate fee does not exceed $1,196.80 (H)	$196.50
51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation mentioned in an item that includes (Assist.) for which the fee exceeds $1,196.80 or at a series or combination of operations mentioned in an item that include (Assist.) if the aggregate fee exceeds $1,196.80. Derived fee: One fifth of the established fee for the operation or combination of operations.	DF
GROUP O3—GENERAL SURGERY		
51900	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)	$777.80
51902	Wounds of the oral and maxillofacial region, dressing of, under general anaesthesia, with or without removal of sutures, other than a service associated with a service to which another item in Groups O3 to O9 applies (H) (Anaes.)	$176.20
51904	Lipectomy wedge excision of skin or fat one excision (H) (Anaes.) (Assist.)	$1,079.40
51906	Lipectomy wedge excision of skin or fat 2 or more excisions (H) (Anaes.) (Assist.)	$1,619.80
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7cm LONG), superficial (Anaes.)	$196.80
52003	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, small (not more than 7cm long), involving deeper tissue (Anaes.)	$280.50
52006	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7cm long), superficial (Anaes.)	$280.50
52009	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	$423.40
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	$597.50
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.)	$104.80
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.)	$429.60
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)	$660.20
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.)	$73.00
52024	Biopsy of skin or mucous membrane, as an independent procedure (Anaes.)	$170.10
52025	Lymph node of neck, biopsy of (Anaes.)	$430.40

Item No.	Description	Max Fee (excl. GST)
52027	BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes.)	$355.30
52030	Sinus, excision of, involving superficial tissue only (Anaes.)	$214.70
52033	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$430.40
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser	$191.50
52035	Endoscopic laser therapy for neoplasia and benign vascular lesions of the oral cavity (Anaes.)	$1,132.50
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.)	$291.40
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)	$777.80
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	$387.20
52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.)	$589.20
52048	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, other than a service to which another item in Groups O3 to O9 applies (H) (Anaes.) (Assist.)	$890.70
52051	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (H) (Anaes.) (Assist.)	$1,200.50
52054	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (H) (Anaes.) (Assist.)	$1,339.70
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding after care)	$65.50
52056	HAEMATOMA, aspiration of (Anaes.)	$65.50
52057	Large haematoma, large abscess, carbuncle, cellulitis or similar lesion in the oral and maxillofacial region, incision with drainage of (excluding after care) (H) (Anaes.)	$388.80
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques - but not including imaging (Anaes.)	$567.20
52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.)	$1,193.60
52060	Muscle in the oral and maxillofacial region, excision of (H) (Anaes.)	$451.30
52061	Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (H) (Anaes.)	$523.80
52062	Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (H) (Anaes.) (Assist.)	$692.40
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	$802.40
52064	BONE CYST, injection into or aspiration of (Anaes.)	$380.10
52066	Submandibular gland, extirpation of (H) (Anaes.) (Assist.)	$1,367.60
52069	Sublingual gland, extirpation of (H) (Anaes.)	$483.30
52072	Salivary gland, dilatation or diathermy of duct (Anaes.)	$152.60
52073	Salivary gland, repair of cutaneous fistula of (H) (Anaes.)	$350.30
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$342.80
52078	Tongue, partial excision of (H) (Anaes.) (Assist.)	$661.00

Item No.	Description	Max Fee (excl. GST)
52081	Tongue tie, division or excision of frenulum (Anaes.)	$190.00
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a patient aged not less than 2 years (Anaes.)	$277.80
52087	Ranula or mucous cyst of mouth, removal of (Anaes.)	$487.60
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.)	$850.10
52092	Operation on skull for osteomyelitis (H) (Anaes.) (Assist.)	$1,087.80
52094	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 52092 (H) (Anaes.) (Assist.)	$1,413.00
52095	Bone growth stimulator in the oral and maxillofacial region, insertion of (H) (Anaes.) (Assist.)	$910.60
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.)	$363.60
52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.)	$381.80
52098	External fixation in the oral and maxillofacial region, removal of, in conjunction with operations involving internal fixation or bone grafting or both (H) (Anaes.)	$446.60
52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (Anaes.)	$336.80
52102	Buried wire, pin or screw, one 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 (H) (Anaes.)	$318.20
52105	Plate, one 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, other than a service associated with a service to which item 52099 or 52102 applies (H) (Anaes.) (Assist.)	$627.20
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.)	$352.70
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.)	$777.80
52111	VERMILIONECTOMY (Anaes.) (Assist.)	$789.60
52114	Mandible or maxilla, segmental resection of, for tumours or cysts (H) (Anaes.) (Assist.)	$1,403.70
52117	Mandible, including lower border, or maxilla, sub total resection of (H) (Anaes.) (Assist.)	$1,650.50
52120	Mandible, hemimandiblectomy of, including condylectomy, if performed (H) (Anaes.) (Assist.)	$3,689.50
52122	Mandible, hemi mandibular reconstruction of, or maxilla reconstruction of, with bone graft, plate, tray or alloplast, other than a service associated with a service to which item 52123 applies (H) (Anaes.) (Assist.)	$3,689.50
52123	Mandible, total resection of both sides, including condylectomies if performed (H) (Anaes.) (Assist.)	$2,192.80
52126	Maxilla, total resection of (H) (Anaes.) (Assist.)	$2,108.50
52129	Maxilla, total resection of both maxillae (H) (Anaes.) (Assist.)	$2,822.30
52130	Bone graft in the oral and maxillofacial region, other than a service to which another item in Groups O3 to O9 applies (H) (Anaes.) (Assist.)	$1,055.90
52131	Bone graft with internal fixation, in the oral and maxillofacial region, other than a service to which another item in the range 51900 to 52186, or the range 52303 to 53460, applies (H) (Anaes.) (Assist.)	$1,718.70
52132	Tracheostomy (Anaes.)	$1,110.10
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	$213.30
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.)	$344.60
52138	Maxillary artery, ligation of (H) (Anaes.) (Assist.)	$1,489.90
52141	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, other than a service to which item 52138 applies (H) (Anaes.) (Assist.)	$1,059.40
52144	Foreign body, deep, removal of using interventional imaging techniques (H) (Anaes.) (Assist.)	$987.00
52147	Duct of major salivary gland, transposition of (H) (Anaes.) (Assist.)	$926.70
52148	Parotid duct, repair of, using micro surgical techniques (H) (Anaes.) (Assist.)	$1,615.30
52158	Submandibular ducts, relocation of, for surgical control of drooling (H) (Anaes.) (Assist.)	$2,644.80

Item No.	Description	Max Fee (excl. GST)
52180	MALIGNANT DISEASE AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.)	$452.50
52182	Bone or malignant deep soft tissue tumour in the oral and maxillofacial region, lesional or marginal excision of (H) (Anaes.) (Assist.)	$928.40
52184	Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any one of liquid nitrogen freezing, autograft, allograft or cementation (H) (Anaes.) (Assist.)	$1,366.10
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 (H) (Anaes.) (Assist.)	$1,797.60
GROUP O4—PLASTIC AND RECONSTRUCTIVE		
52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.)	$678.70
52303	Single-stage local flap, if indicated, repair to one defect, with buccal pad of fat (H) (Anaes.) (Assist.)	$968.60
52306	Single-stage local flap, if indicated, repair to one defect, using temporalis muscle (H) (Anaes.) (Assist.)	$1,437.50
52309	Free grafting (mucosa or split skin) of a granulating area (Anaes.)	$479.30
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.)	$677.10
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.)	$1,115.30
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 (H) (Anaes.)	$422.00
52319	Bone graft, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies Autogenous, large quantity (H) (Anaes.)	$767.80
52321	Foreign implant (non-biological), insertion of, for contour reconstruction of pathological deformity, other than a service associated with a service to which item 52624 applies (H) (Anaes.) (Assist.)	$1,143.70
52324	Direct flap repair, using tongue, first stage (H) (Anaes.) (Assist.)	$1,929.70
52327	Direct flap repair, using tongue, second stage (H) (Anaes.)	$1,025.80
52330	Palatal defect (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (H) (Anaes.) (Assist.)	$1,764.10
52333	Cleft palate, primary repair (H) (Anaes.) (Assist.)	$1,831.00
52336	Cleft palate, secondary repair, closure of fistula using local flaps (H) (Anaes.) (Assist.)	$1,100.20
52337	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (H) (Anaes.) (Assist.)	$2,435.60
52339	Cleft palate, secondary repair, lengthening procedure (H) (Anaes.) (Assist.)	$1,303.20
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2,295.00
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$2,481.30
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2,775.50
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$4,722.60
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$3,334.20
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$4,348.80
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$3,595.40
52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$5,867.30
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$4,229.70

Item No.	Description	Max Fee (excl. GST)
52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$6,781.20
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$4,614.10
52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	$6,223.00
52378	Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	$2,673.90
52379	Face, contour reconstruction of one region, using autogenous bone or cartilage graft (H) (Anaes.) (Assist.)	$3,141.20
52380	Midfacial osteotomies Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	$5,139.70
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 (H) (Anaes.) (Assist.)	$6,953.70
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity (H)	$654.80
52424	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) in the oral and maxillofacial region (H) (Anaes.) (Assist.)	$1,533.30
52430	Microvascular repair of the oral and maxillofacial region using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (H) (Anaes.) (Assist.)	$2,553.10
52440	Cleft lip, unilateral primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	$1,267.80
52442	Cleft lip, unilateral primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	$1,584.90
52444	Cleft lip, bilateral primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	$1,760.70
52446	Cleft lip, bilateral primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	$2,078.10
52450	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (H) (Anaes.)	$704.20
52452	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (H) (Anaes.) (Assist.)	$1,166.40
52456	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (H) (Anaes.) (Assist.)	$1,937.10
52458	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (H) (Anaes.)	$704.20
52460	Velo pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (H) (Anaes.)	$1,831.00
52480	Composite graft (chondro cutaneous or chondro mucosal) to nose, ear or eyelid (H) (Anaes.) (Assist.)	$1,176.00
52482	Macrocheilia or macroglossia, operation for (H) (Anaes.) (Assist.)	$1,131.70
52484	Macrostomia, operation for (H) (Anaes.) (Assist.)	$1,347.00
GROUP O5—PREPROSTHETIC		
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)	$754.90
52603	Mylohyoid ridge, reduction of (H) (Anaes.) (Assist.)	$771.70
52606	Maxillary tuberosity, reduction of (Anaes.)	$588.60
52609	Papillary hyperplasia of the palate, removal of less than 5 lesions (H) (Anaes.) (Assist.)	$771.70
52612	Papillary hyperplasia of the palate, removal of 5 to 20 lesions (H) (Anaes.) (Assist.)	$968.60
52615	Papillary hyperplasia of the palate, removal of more than 20 lesions (H) (Anaes.) (Assist.)	$1,202.60
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)	$1,399.70
52621	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed unilateral (H) (Anaes.) (Assist.)	$2,086.70
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.)	$1,057.80

Item No.	Description	Max Fee (excl. GST)
52626	Alveolar ridge augmentation unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (H) (Anaes.) (Assist.)	$676.90
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.)	$1,136.30
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.)	$463.30
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.)	$1,704.30
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.)	$821.90
GROUP O6—NEUROSURGICAL		
52800	Neurolysis by open operation, without transposition, other than a service associated with a service to which item 52803 applies (H) (Anaes.) (Assist.)	$661.70
52803	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (H) (Anaes.) (Assist.)	$951.00
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.)	$648.10
52809	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve (H) (Anaes.) (Assist.)	$1,109.20
52812	Nerve trunk, primary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	$1,615.40
52815	Nerve trunk, secondary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	$3,079.40
52818	Nerve, transposition of (H) (Anaes.) (Assist.)	$1,105.10
52821	Nerve graft to nerve trunk (cable graft) including harvesting of nerve graft using microsurgical techniques (H) (Anaes.) (Assist.)	$2,412.60
52824	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (H) (Anaes.) (Assist.)	$1,058.40
52826	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (H) (Anaes.)	$556.50
52828	Cutaneous nerve, primary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	$827.60
52830	Cutaneous nerve, secondary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	$1,091.50
52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.)	$1,496.80
GROUP O7—EAR, NOSE AND THROAT		
53000	Maxillary antrum, proof puncture and lavage of (Anaes.)	$74.50
53003	Maxillary antrum, proof puncture and lavage of, under general anaesthesia, other than a service associated with a service to which another item in Groups O3 to O9 applies (H) (Anaes.)	$218.20
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.)	$121.70
53006	Antrostomy (radical) (H) (Anaes.) (Assist.)	$1,244.00
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.)	$706.40
53012	Antrum, drainage of, through tooth socket (Anaes.)	$280.60
53015	Oro antral fistula, plastic closure of (Anaes.) (Assist.)	$1,402.50
53016	Nasal septum, septoplasty, submucous resection or closure of septal perforation (H) (Anaes.) (Assist.)	$1,285.70
53017	Nasal septum, reconstruction of (H) (Anaes.) (Assist.)	$2,450.50
53019	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (H) (Anaes.) (Assist.)	$1,417.30
53052	Post-nasal space, direct examination of, with or without biopsy (Anaes.)	$287.30
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.)	$506.90
53056	Examination of nasal cavity or post nasal space, or nasal cavity and post nasal space, under general anaesthesia, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	$171.60
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)	$287.30

Item No.	Description	Max Fee (excl. GST)
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) one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (H) (Anaes.)	$235.30
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$210.70
53064	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	$381.30
53068	Turbinectomy or turbinectomies, partial or total, unilateral (H) (Anaes.)	$608.60
53070	Turbinates, submucous resection of, unilateral (H) (Anaes.)	$542.00
GROUP O8—TEMPOROMANDIBULAR JOINT		
53200	Mandible, treatment of a dislocation of, not requiring open reduction (Anaes.)	$167.90
53203	Mandible, treatment of a dislocation of, requiring open reduction (H) (Anaes.)	$277.90
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.)	$319.40
53209	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (H) (Anaes.) (Assist.)	$3,861.40
53212	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.)	$2,087.40
53215	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (H) (Anaes.) (Assist.)	$1,822.70
53218	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions one or more of such procedures (H) (Anaes.) (Assist.)	$1,833.20
53220	Temporomandibular joint, arthrotomy of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$771.70
53221	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (H) (Anaes.) (Assist.)	$2,077.80
53224	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (H) (Anaes.) (Assist.)	$2,264.40
53225	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (Anaes.) (Assist.)	$691.40
53226	Temporomandibular joint, synovectomy of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$731.60
53227	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (H) (Anaes.) (Assist.)	$2,782.50
53230	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (H) (Anaes.) (Assist.)	$4,742.30
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 (H) (Anaes.) (Assist.)	$5,023.90
53236	Temporomandibular joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,102.00
53239	Temporomandibular joint, arthrodesis of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$1,102.00
53242	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.)	$745.40
GROUP O9—TREATMENT OF FRACTURES		
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting	$302.30
53403	Mandible, treatment of fracture of, not requiring splinting	$376.60
53406	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	$1,195.50
53409	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	$965.00
53410	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	$200.50

Item No.	Description	Max Fee (excl. GST)
53411	Zygomatic bone, treatment of fracture of, requiring surgical reduction, by temporal, intra oral or other approach (H) (Anaes.)	$627.60
53412	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one site (H) (Anaes.) (Assist.)	$931.90
53413	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (H) (Anaes.) (Assist.)	$1,149.70
53414	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (H) (Anaes.) (Assist.)	$1,614.50
53415	Maxilla, treatment of fracture of, requiring open reduction (H) (Anaes.) (Assist.)	$1,038.60
53416	Mandible, treatment of fracture of, requiring open reduction (H) (Anaes.) (Assist.)	$1,039.90
53418	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.)	$1,326.60
53419	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.)	$1,345.40
53422	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.)	$1,885.60
53423	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.)	$1,702.60
53424	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (H) (Anaes.) (Assist.)	$2,123.90
53425	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (H) (Anaes.) (Assist.)	$1,492.80
53427	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (H) (Anaes.) (Assist.)	$1,999.80
53429	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (H) (Anaes.) (Assist.)	$1,896.30
53439	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	$567.10
53453	Orbital cavity, reconstruction of a wall or floor with or without foreign implant (H) (Anaes.) (Assist.)	$1,219.10
53455	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (H) (Anaes.) (Assist.)	$1,853.80
53458	Nasal bones, treatment of fracture of, not being a service to which item 53459 or 53460 applies	$102.50
53459	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$558.70
53460	Nasal bones, treatment of fractures of, by open reduction involving osteotomies (H) (Anaes.) (Assist.)	$1,764.90
GROUP O11—REGIONAL OR FIELD NERVE BLOCKS		
53700	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.)) TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent	$292.50
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent	$146.50
53704	Facial nerve, injection of an anaesthetic agent	$87.90
53706	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies	$556.80
GROUP I1—ULTRASOUND		
	General	
55028	Head, ultrasound scan of (R)	$240.90
55029	Head, ultrasound scan of (NR)	$84.70
55030	Orbital contents, ultrasound scan of (R)	$244.10
55031	Orbital contents, ultrasound scan of (NR)	$86.20
55032	Neck, one or more structures of, ultrasound scan of (R)	$251.70
55033	Neck, one or more structures of, ultrasound scan of (NR)	$84.30

Item No.	Description	Max Fee (excl. GST)
55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra; and (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R)	$259.50
55037	Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra (NR)	$84.70
55038	Urinary tract, ultrasound scan of, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra; and (b) within 24 hours of the service, a service mentioned in item 55036 or 55065 is not performed on the same patient by the providing practitioner (R)	$254.30
55039	Urinary tract, ultrasound scan of, if the service is not solely a transrectal ultrasonic examination of any of the following: (a) prostate gland; (b) bladder base; (c) urethra (NR)	$84.30
55048	Scrotum, ultrasound scan of (R)	$255.60
55049	Scrotum, ultrasound scan of (NR)	$86.60
55054	Ultrasonic cross-sectional echography, in conjunction with a surgical procedure (other than a procedure to which item 55848 or 55850 applies) using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R)	$252.30
55065	Pelvis, ultrasound scan of, by any or all approaches, if: (a) the service is not solely a service to which an item (other than item 55736 or 55739) in Subgroup 5 of this Group applies or a transrectal ultrasonic examination of any of the following: prostate gland; bladder base; urethra; and (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R)	$232.40
55066	Breasts, both, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if: (a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and (b) the service is not performed in conjunction with any other item in this Group (R)	$463.40
55068	Pelvis, ultrasound scan of, by any or all approaches, if the service is not solely a service to which an item (other than item 55736 or 55739) in Subgroup 5 of this Group applies or a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra (NR)	$82.90
55070	Breast, one, ultrasound scan of (R)	$220.50
55071	Breast, one, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if: (a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and (b) the service is not performed in conjunction with any other item in this group (R)	$440.40
55073	Breast, one, ultrasound scan of (NR)	$75.10
55076	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (R)	$241.20
55079	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (NR)	$93.40
55080	Pelvis, ultrasound scan of, by any or all approaches (including transvaginal), if: (a) the patient is known to have, or the requesting practitioner suspects, a complex gynaecological condition; and (b) the service is considered a complex investigation requiring a minimum of 30 minutes scanning time; and (c) within 24 hours of the service, a service mentioned in item 55038, 55065, 55700, 55704, 55736, or 55739 is not performed on the same patient. (R)	$382.50
55084	Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55036, 55038, 55065, 55600 or 55603 is not performed on the same patient by the providing practitioner (R)	$217.00
55085	Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55037, 55039, 55068, 55600 or 55603 is not performed on the same patient by the providing practitioner (NR)	$78.50
	Cardiac	
55118	Heart, two dimensional or three dimensional real time transoesophageal examination of, from at least 2 levels, and in more than one plane at each level, if: (a) the service includes: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on digital media; and (b) the service is not: (i) an intra operative service; or (ii) a service associated with a service to which an item in Subgroup 3 of this Group applies (R) (H) (Anaes.)	$607.60
55130	Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography, if the service: (a) includes Doppler techniques with colour flow mapping and recordings on digital media; and (b) is performed during cardiac surgery; and (c) incorporates sequential assessment of cardiac function before and after the surgical procedure; and (d) is not associated with a service to which item 55135, or an item in Subgroup 3, applies (R) (H) (Anaes.)	$375.40

Item No.	Description	Max Fee (excl. GST)
55135	Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography, if the service: (a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and (b) includes Doppler techniques with colour flow mapping and recordings on digital media; and (c) is performed during cardiac valve surgery (replacement or repair); and (d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and (e) is not associated with a service to which item 22054, 55130, or an item in Subgroup 3, applies (R) (H) (Anaes.)	$781.20
	Vascular	
55238	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with any of the following: (a) a service to which an item in Subgroup 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$392.30
55244	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with any of the following: (a) a service to which item 55246 applies; (b) a service to which an item in Subgroup 4 applies; (c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$393.30
55246	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with any of the following: (a) a service to which item 55244 applies; (b) a service to which an item in Subgroup 4 applies; (c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$394.70
55248	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$393.10
55252	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroup 4 applies (R).	$391.20
55274	Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri orbital Doppler examination, not being a service associated with a service to which an item in Subgroup 4 applies (R).	$391.10
55276	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$393.60
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 4 applies (R)	$372.90
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 4 applies (R)	$378.40
55282	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements: (a) by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent; and (b) performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence; and (c) if a specialist in diagnostic radiology, nuclear medicine, sexual health medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$373.80
55284	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements: (a) by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis; and (b) if indicated, assess the progress and management of: (i) priapism; or (ii) fibrosis of any type; or (iii) fracture of the tunica; or (iv) arteriovenous malformations; and (c) if a specialist in diagnostic radiology, nuclear medicine, sexual health medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$374.50
55292	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access grafts in the upper or lower limbs, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$376.40

Item No.	Description	Max Fee (excl. GST)
55294	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins, or both, including any associated skin marking, for mapping of bypass conduit before vascular surgery, not being a service associated with any of the following: (a) a service to which an item in Subgroup 3 or 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$373.90
55296	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limbs below the inguinal ligament before varicose vein surgery, including any associated skin marking, not being a service associated with any of the following: (a) a service to which an item in Subgroup 3 or 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$246.90
	Urological	
55600	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient s current prostatic disease (R)	$254.60
55603	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient s current prostatic disease (R)	$246.50
	Obstetric and gynaecological	
55700	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is less than 12 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55704, 55705, 55707, 55708, 55740, 55741, 55742 or 55743 (R)	$139.70
55703	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is less than 12 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55704, 55705, 55707, 55708, 55740, 55741, 55742 or 55743 (NR)	$77.40
55704	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R)	$155.70
55705	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR)	$77.40
55706	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the dating for the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55709; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$233.10
55707	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R)	$227.30
55709	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55706; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$119.30

Item No.	Description	Max Fee (excl. GST)
55712	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the current ultrasound is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$254.20
55715	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (b) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$88.30
55718	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55723; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$223.80
55721	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the current ultrasound is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by current ultrasound) is after 22 weeks of gestation; and (c) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$254.20
55723	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55718; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$83.90
55725	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$88.30
55729	Duplex scanning, if: (a) the service involves: (i) B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery; and (ii) measured assessment of amniotic fluid volume after the 24th week of gestation; and (b) there is reason to suspect intrauterine growth retardation or a significant risk of fetal death; examination and report (R)	$60.20
55736	Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)	$319.90
55739	Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)	$132.20
55740	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R)	$221.00
55741	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR)	$110.60

Item No.	Description	Max Fee (excl. GST)
55742	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84mm; and (c) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R)	$221.00
55743	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84mm; and (c) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR)	$110.60
55757	Pelvis or abdomen, ultrasound (the current ultrasound) scan of, for cervical length assessment for risk of preterm labour, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is between 14 and 30 weeks of gestation; and (b) any of the following apply: (i) the patient has a history indicating high risk of preterm labour or birth or second trimester fetal loss; (ii) the patient has symptoms suggestive of threatened preterm labour or second trimester fetal loss; (iii) the patient s cervical length is less than 25mm on an ultrasound before 28 weeks gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R)	$105.20
55758	Pelvis or abdomen, ultrasound (the current ultrasound) scan of, for cervical length assessment for risk of preterm labour, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is between 14 and 30 weeks of gestation; and (b) any of the following apply: (i) the patient has a history indicating high risk of preterm labour or birth or second trimester fetal loss; (ii) the patient has symptoms suggestive of threatened preterm labour or second trimester fetal loss; (iii) the patient s cervical length is less than 25mm on an ultrasound before 28 weeks gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR)	$40.10
55759	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55762 is not performed in conjunction with the current ultrasound during the same pregnancy; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$331.10
55762	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55759 is not performed in conjunction with the current ultrasound during the same pregnancy; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$170.00
55764	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks gestation; and (d) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (e) the service mentioned in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the current ultrasound during the same pregnancy; and (f) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$353.40
55766	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (d) the service mentioned in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$143.80
55768	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) an ultrasound confirms a multiple pregnancy; and (c) the service is not performed in the same pregnancy as item 55770; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$331.50

Item No.	Description	Max Fee (excl. GST)
55770	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) an ultrasound confirms a multiple pregnancy; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$132.50
55772	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) dating of the pregnancy as confirmed by the current ultrasound is after 22 weeks of gestation; and (b) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by an ultrasound is a multiple pregnancy; and (e) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (f) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R)	$353.40
55774	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) dating of the pregnancy as confirmed by the current ultrasound is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (c) the pregnancy as confirmed by an ultrasound is a multiple pregnancy; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR)	$143.80
	Musculoskeletal	
55812	Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (R)	$253.80
55814	Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (NR)	$88.00
55844	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (R)	$202.50
55846	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (NR)	$83.70
55848	Musculoskeletal ultrasound, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with a service mentioned in item 55054 (R)	$299.50
55850	Musculoskeletal ultrasound, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, if: (a) the medical practitioner or nurse practitioner has indicated on a request for a musculoskeletal ultrasound that an ultrasound guided intervention be performed if clinically indicated; and (b) the service is not performed in conjunction with a service mentioned in item 55054 or any other item in this Subgroup (R)	$405.60
55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (R)	$241.40
55854	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (NR)	$83.70
55856	Hand or wrist or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55858 (R)	$242.70
55857	Hand or wrist, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55859 (NR)	$88.00
55858	Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55856 (R)	$278.70
55859	Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55857 (NR)	$96.80
55860	Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55862 (R)	$240.50
55861	Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55863 (NR)	$87.70
55862	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55860 (R)	$275.70

Item No.	Description	Max Fee (excl. GST)
55863	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55861 (NR)	$96.50
55864	Shoulder or upper arm, or both, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55866 (R)	$242.80
55865	Shoulder or upper arm, or both, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55867 (NR)	$87.90
55866	Shoulder or upper arm, or both, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55864 (R)	$278.80
55867	Shoulder or upper arm, or both, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55865 (NR)	$98.20
55868	Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55870 (R)	$253.20
55869	Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55871 (NR)	$88.00
55870	Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55868 (R)	$278.50
55871	Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55869 (NR)	$96.80
55876	Buttock or thigh, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55878 (R)	$253.20
55877	Buttock or thigh or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55879 (NR)	$82.60
55878	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55876 (R)	$278.50
55879	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55877 (NR)	$93.20
55880	Knee, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55882 (R)	$252.50
55881	Knee, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55883 (NR)	$88.00
55882	Knee, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with a service mentioned in item 55880 (R)	$277.50
55883	Knee, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55881 (NR)	$96.80
55884	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55886 (R)	$251.80

Item No.	Description	Max Fee (excl. GST)
55885	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55887 (NR)	$88.30
55886	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55884 (R)	$276.30
55887	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55885 (NR)	$98.50
55888	Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55890 (R)	$254.80
55889	Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55891 (NR)	$88.00
55890	Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55888 (R)	$280.00
55891	Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55889 (NR)	$96.80
55892	Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55894 (R)	$257.90
55893	Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55895 (NR)	$83.90
55894	Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55892 (R)	$264.30
55895	Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55893 (NR)	$93.80
	Cardiac	
55126	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Initial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of any of the following: (i) symptoms or signs of cardiac failure; (ii) suspected or known ventricular hypertrophy or dysfunction; (iii) pulmonary hypertension; (iv) valvular, aortic, pericardial, thrombotic or embolic disease; (v) heart tumour; (vi) symptoms or signs of congenital heart disease; (vii) other rare indications; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R)	$497.30
55127	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of known valvular dysfunction; and (b) is requested by a specialist or consultant physician; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$497.30
55128	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of known valvular dysfunction; and (b) is requested by a medical practitioner (other than a specialist or consultant physician) at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$497.30
55129	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if: (a) valvular dysfunction is not the primary issue for the patient (although it may be a secondary issue); and (b) the service is for the investigation of any of the following: (i) symptoms or signs of cardiac failure; (ii) suspected or known ventricular hypertrophy or dysfunction; (iii) pulmonary hypertension; (iv) aortic, thrombotic, embolic disease or pericardial disease (excluding isolated pericardial effusion or pericarditis); (v) heart tumour; (vi) structural heart disease; (vii) other rare indications; and (c) the service is requested by a specialist or consultant physician; and (d) the service is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$497.30
55132	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 4 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a patient who: (i) is under 17 years of age; or (ii) has complex congenital heart disease; and (b) is performed by a specialist or consultant physician practising in the speciality of cardiology; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$497.30

Item No.	Description	Max Fee (excl. GST)
55133	Note: the service only applies if the patient meets one or more of the following and the requirements of Note: IR.1.2 Frequent repetition serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a patient who: (i) has an isolated pericardial effusion or pericarditis; or (ii) has a normal baseline study, and has commenced medication for non cardiac purposes that has cardiotoxic side effects and is a pharmaceutical benefit (within the meaning of Part VII of the National Health Act 1953) for the writing of a prescription for the supply of which under that Part an echocardiogram is required; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$447.60
55134	Note: the service only applies if the patient meets one or more of the following and the requirements of Note: IR.1.2 Repeat real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, for the investigation of rare cardiac pathologies, if the service: (a) is requested by a specialist or consultant physician; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$497.30
55137	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 4 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a fetus with suspected or confirmed: (i) complex congenital heart disease; or (ii) functional heart disease; or (iii) fetal cardiac arrhythmia; or (iv) cardiac structural abnormality requiring confirmation; and (b) is performed by a specialist or consultant physician practising in the speciality of cardiology with advanced training and expertise in fetal cardiac imaging; and (c) is not associated with a service to which: (i) an item in Subgroup 2 applies (except items 55118 and 55130); or (ii) an item in Subgroup 3 applies (R)	$497.30
55141	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 and does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55143, 55145 or 55146 applies has been provided to the patient. Exercise stress echocardiography focused study, other than a service associated with a service to which: (a) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (b) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R)	$886.80
55143	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1, IR.1.1 and IR.1.2 Repeat pharmacological or exercise stress echocardiography if: (a) a service to which item 55141, 55145, 55146, or this item, applies has been performed on the patient in the previous 24 months; and (b) the patient has symptoms of ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which: (i) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (ii) an item in Subgroup 3 applies Applicable not more than once in a 12 month period (R)	$886.80
55145	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Pharmacological stress echocardiography, other than a service associated with a service to which: (a) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (b) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) Note: this item does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55141, 55143 or 55146 applies has been provided to the patient.	$1,027.90
55146	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Pharmacological stress echocardiography if: (a) a service to which item 55141 applies has been performed on the patient in the previous 4 weeks, and the test has failed due to an inadequate heart rate response; and (b) the service is not associated with a service to which: (i) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (ii) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) Note: this item does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55143 or 55145 applies has been provided to the patient.	$1,027.90
GROUP I2—COMPUTED TOMOGRAPHY		
56001	Computed tomography scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (Anaes.)	$417.40
56007	Computed tomography scan of brain with intravenous contrast medium and with any scans of the brain before intravenous contrast injection, when performed, not being a service to which item 57007 applies (R) (Anaes.)	$582.10
56010	Computed tomography scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (Anaes.)	$561.70
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (Anaes.)	$576.50
56016	Computed tomography scan of petrous bones in axial and coronal planes in 1mm or 2mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (Anaes.)	$680.50
56022	Computed tomography scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (Anaes.)	$518.80

Item No.	Description	Max Fee (excl. GST)
56028	Computed tomography scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both before intravenous contrast injection, when performed (R) (Anaes.)	$745.40
56030	Computed tomography scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (Anaes.)	$523.80
56036	Computed tomography scan of facial bones, para nasal sinuses or both, with scan of brain, with intravenous contrast medium, if: (a) a scan without intravenous contrast medium has been performed; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (Anaes.)	$749.50
56101	Computed tomography scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (Anaes.)	$508.70
56107	Computed tomography scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) with intravenous contrast medium and with any scans of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) before intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (Anaes.)	$783.30
56219	Computed tomography scan of spine, one or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X rays, not being a service to which item 59724 applies (R) (Anaes.)	$729.60
56220	Computed tomography scan of spine, cervical region, without intravenous contrast medium (R) (Anaes.)	$554.80
56221	Computed tomography scan of spine, thoracic region, without intravenous contrast medium (R) (Anaes.)	$563.50
56223	Computed tomography scan of spine, lumbosacral region, without intravenous contrast medium (R) (Anaes.)	$559.90
56224	Computed tomography scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$812.60
56225	Computed tomography scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$751.10
56226	Computed tomography scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken (R) (Anaes.)	$796.70
56233	Computed tomography scan of spine, 2 examinations of the kind referred to in items 56220, 56221 and 56223, without intravenous contrast medium (R) (Anaes.)	$554.30
56234	Computed tomography scan of spine, 2 examinations of the kind referred to in items 56224, 56225 and 56226, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$778.10
56237	Computed tomography scan of spine, 3 regions cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (Anaes.)	$554.80
56238	Computed tomography scan of spine, 3 regions, cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$783.10
56301	Computed tomography scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$683.90
56307	Computed tomography scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest, including lungs, mediastinum, chest wall or pleura and upper abdomen before intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$916.70
56401	Computed tomography scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (Anaes.)	$538.50
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) before intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (Anaes.)	$795.10
56409	Computed tomography scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (Anaes.)	$572.20
56412	Computed tomography scan of pelvis only (iliac crest to pubic symphysis), with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) before intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (Anaes.)	$838.20
56501	Computed tomography scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy and not being a service to which item 56801 or 57001 applies (R) (Anaes.)	$856.20

Item No.	Description	Max Fee (excl. GST)
56507	Computed tomography scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis before intravenous contrast injection, when performed, not for the purposes of virtual colonoscopy and not being a service to which item 56807 or 57007 applies (R) (Anaes.)	$1,112.40
56553	Computed tomography scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if: (a) one or more of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high grade colonic obstruction; (iii) the service is requested by a specialist or consultant physician who performs colonoscopies in the practice of the specialist'sor consultant physician's speciality; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (Anaes.)	$1,201.70
56620	Computed tomography scan of knee, without intravenous contrast medium, not being a service to which item 56622 or 56629 applies (R) (Anaes.)	$479.40
56622	Computed tomography scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium, not being a service to which item 56620 applies (R) (Anaes.)	$509.20
56623	Computed tomography scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of the lower limb before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.)	$777.40
56626	Computed tomography scan of knee, with intravenous contrast medium and with any scans of the knee before intravenous contrast injection, when performed, not being a service to which items 56623 or 56630 apply (R) (Anaes.)	$729.30
56627	Computed tomography scan of upper limb, left or right or both, any one region, or more than one region, without intravenous contrast medium (R) (Anaes.)	$509.20
56628	Computed tomography scan of upper limb, left or right or both, any one region, or more than one region, with intravenous contrast medium and with any scans of the upper limb before intravenous contrast injection, when performed (R) (Anaes.)	$777.40
56629	Computed tomography scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) without intravenous contrast medium not being a service to which item 56620 applies (R) (Anaes.)	$509.20
56630	Computed tomography scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) with intravenous contrast medium with any scans of the limbs before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.)	$777.40
56801	Computed tomography scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$1,057.30
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 before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$1,280.30
57001	Computed tomography scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$1,067.70
57007	Computed tomography scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$1,315.70
57201	Computed tomography pelvimetry (R) (Anaes.)	$331.60
57341	Computed tomography, in conjunction with a surgical procedure using interventional techniques (R) (Anaes.)	$1,018.50
57352	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the arch of the aorta; or (b) the carotid arteries; or (c) the vertebral arteries and their branches (head and neck); including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (d) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (e) the service is not a service to which another item in this group applies; and (f) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (g) the service is not a study performed to image the coronary arteries (R) (Anaes.)	$1,091.40

Item No.	Description	Max Fee (excl. GST)
57353	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the ascending and descending aorta; or (b) the common iliac and abdominal branches including upper limbs (chest, abdomen and upper limbs); including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.)	$1,091.40
57354	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the descending aorta; or (b) the pelvic vessels (aorto iliac segment) and lower limbs; including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.)	$1,091.40
57357	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of the pulmonary arteries and their branches, including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: the service is not a service to which another item in this group applies; and the service is not a study performed to image the coronary arteries; and the service is: (i) performed for the exclusion of pulmonary arterial stenosis, occlusion, aneurysm or embolism and is requested by a specialist or consultant physician; or (ii) performed for the exclusion of pulmonary arterial stenosis, occlusion or aneurysm and is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; or (iii) for the exclusion of pulmonary embolism and is requested be a medical practitioner (other than a specialist or consultant physician) (R) (Anaes.)	$1,099.50
57360	Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner if: (a) the request is made by a specialist or consultant physician; and (b) the patient has stable or acute symptoms consistent with coronary ischaemia; and (c) the patient is at low to intermediate risk of an acute coronary event, including having no significant cardiac biomarker elevation and no electrocardiogram changes indicating acute ischaemia (R) Note: See explanatory note IN.2.2 for claiming restrictions for this item. (Anaes.)	$1,558.30
57362	Cone beam computed tomography dental and temporo mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following: (a) mandibular and dento alveolar fractures; (b) dental implant planning; (c) orthodontics; (d) endodontic conditions; (e) periodontal conditions; (f) temporo mandibular joint conditionsApplicable once per patient per day, not being for a service to which any of items 57960 to 57969 apply, and not being a service associated with another service in Group I2 (R) (Anaes.)	$242.90
57364	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 (item 38247), TR.8.2 (item 38249) or item 38252 if subclause (iv) applies. Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner, if: (a) the service is requested by a specialist or consultant physician; and (b) at least one of the following apply to the patient: (i) the patient has stable symptoms and newly recognised left ventricular systolic dysfunction of unknown aetiology; (ii) the patient requires exclusion of coronary artery anomaly or fistula; (iii) the patient will be undergoing non-coronary cardiac surgery; (iv) the patient meets the criteria to be eligible for a service to which item 38247, 38249 or 38252 applies, but as an alternative to selective coronary angiography will require an assessment of the patency of one or more bypass grafts (R) (Anaes.)	$1,522.90
GROUP I3—DIAGNOSTIC RADIOLOGY		
	Radiographic examination of extremities	
57506	Hand, wrist, forearm, elbow or humerus (NR)	$70.00
57509	Hand, wrist, forearm, elbow or humerus (R)	$87.90
57512	Hand and wrist, or hand, wrist and forearm, or wrist and forearm, or forearm and elbow, or elbow and humerus (NR)	$89.40
57515	Hand and wrist, or hand, wrist and forearm, or wrist and forearm, or forearm and elbow, or elbow and humerus (R)	$127.20

Item No.	Description	Max Fee (excl. GST)
57518	Foot, ankle, leg or femur (NR)	$74.90
57521	Foot, ankle, leg or femur (R)	$96.00
57522	Knee (NR)	$71.00
57523	Knee (R)	$94.50
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR)	$115.10
57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R)	$152.20
	Radiographic examination of shoulder or pelvis	
57700	Shoulder or scapula (NR)	$95.80
57703	Shoulder or scapula (R)	$120.40
57706	Clavicle (NR)	$74.70
57709	Clavicle (R)	$100.10
57712	Hip joint (R)	$109.60
57715	Pelvic girdle (R)	$139.80
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R)	$218.90
	Radiographic examination of head	
57901	Skull, not in association with item 57902 (R)	$150.30
57902	Cephalometry, not in association with item 57901 (R)	$149.20
57905	Mastoids or petrous temporal bones (R)	$137.10
57907	Sinuses or facial bones orbit, maxilla or malar, any or all (R)	$100.50
57915	Mandible, not by orthopantomography technique (R)	$110.00
57918	Salivary calculus (R)	$105.80
57921	Nose (R)	$110.00
57924	Eye (R)	$107.90
57927	Temporo mandibular joints (R)	$115.10
57930	Teeth single area (R)	$72.00
57933	Teeth - full mouth (R)	$182.80
57939	Palato pharyngeal studies with fluoroscopic screening (R)	$143.40
57942	Palato pharyngeal studies without fluoroscopic screening (R)	$109.70
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)	$100.30
57960	Orthopantomography for diagnosis or management (or both) of trauma, infection, tumour or a congenital or surgical condition of the teeth or maxillofacial region (R)	$108.50
57963	Orthopantomography for diagnosis or management (or both) of any of the following conditions, if the signs and symptoms of the condition is present: (a) impacted teeth; (b) caries; (c) periodontal pathology; (d) periapical pathology (R)	$108.40
57966	Orthopantomography for diagnosis or management (or both) of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R)	$111.00
57969	Orthopantomography for diagnosis or management (or both) of temporo mandibular joint arthroses or dysfunction (R)	$105.80
	Radiographic examination of spine	
58100	Spine cervical (R)	$155.60
58103	Spine thoracic (R)	$128.00
58106	Spine lumbosacral (R)	$178.30
58108	Spine 4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R)	$254.40
58109	Spine sacrococcygeal (R)	$108.70
58112	Spine 2 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R)	$227.90

Item No.	Description	Max Fee (excl. GST)
58115	Spine 3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R)	$254.40
58120	Spine 4 regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R)	$254.40
58121	Spine 3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R)	$243.50
	Bone age study and skeletal surveys	
58300	Bone age study (R)	$94.40
58306	Skeletal survey (R)	$199.50
	Radiographic examination of thoracic region	
58500	Chest (lung fields) by direct radiography (NR)	$77.60
58503	Chest (lung fields) by direct radiography (R)	$108.70
58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R)	$141.50
58509	Thoracic inlet or trachea (R)	$93.70
58521	Left ribs, right ribs or sternum (R)	$100.60
58524	Left and right ribs, left ribs and sternum, or right ribs and sternum (R)	$130.50
58527	Left ribs, right ribs and sternum (R)	$157.80
	Radiographic examination of urinary tract	
58700	Plain renal only (R)	$107.00
58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography (R)	$350.60
58715	Antegrade or retrograde pyelography with or without preliminary plain films and with preparation and contrast injection, one side (R)	$340.00
58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	$280.60
58721	Retrograde micturating cysto urethrography, with preparation and contrast injection (R) (Anaes.)	$316.40
	Radiographic examination of alimentary tract and biliary system	
58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912 or 58915 applies (NR)	$80.20
58903	Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R)	$109.90
58909	Barium or other opaque meal of one or more of pharynx, oesophagus, stomach or duodenum, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942 or 57945 applies (R)	$198.60
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)	$259.60
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R)	$182.70
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.)	$309.70
58921	Opaque enema, with or without air contrast study and with or without preliminary plain films (R)	$298.90
58927	Cholegraphy direct, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies (R)	$171.00
58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection (R)	$463.10
58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography (R)	$430.50
58939	Defaecogram (R)	$321.00
	Radiographic examination for localisation of foreign bodies	
59103	Localisation of foreign body, if provided in conjunction with a service described in subgroups 1 to 12 of group i3 (r)	$49.30

Item No.	Description	Max Fee (excl. GST)
	Radiographic examination of breasts	
59300	Mammography of both breasts if there is reason to suspect the presence of malignancy because of: (a) the past occurrence of breast malignancy in the patient; or (b) significant history of breast or ovarian malignancy in the patient s family; or (c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R) (Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)	$206.50
59302	Three dimensional tomosynthesis of both breasts, if there is reason to suspect the presence of breast malignancy because of: (a) the past occurrence of breast malignancy in the patient; or (b) significant history of breast or ovarian malignancy in the patient s family; or (c) symptoms or signs found on examination of the patient by a medical practitioner; not being a service to which item 59300 applies (R)	$440.10
59303	Mammography of one breast if: (a) the service is specifically requested for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient; or (ii) significant history of breast or ovarian malignancy in the patient s family; or (iii) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R)	$119.30
59305	Three dimensional tomosynthesis of one breast, if there is reason to suspect the presence of breast malignancy because of: (a) the past occurrence of breast malignancy in the patient; or (b) significant history of breast or ovarian malignancy in the patient s family; or (c) symptoms or signs found on examination of the patient by a medical practitioner; not being a service to which item 59303 applies (R)	$248.50
59312	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques (R)	$197.10
59314	Radiographic examination of one breast, in conjunction with a surgical procedure using interventional techniques (R)	$130.00
59318	Radiographic examination of excised breast tissue to confirm satisfactory excision of one or more lesions in one breast or both following pre-operative localisation in conjunction with a service under item 31536 (R)	$106.60
	Radiographic examination with opaque or contrast media	
59700	Discography, each disc, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	$226.40
59703	Dacryocystography, one side, with or without preliminary plain film and with preparation and contrast injection (R)	$170.90
59712	Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	$253.30
59715	Bronchography, one side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age (R) (Anaes.)	$315.70
59718	Phlebography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	$313.90
59724	Myelography, one or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies (R) (Anaes.)	$515.50
59733	Sialography, one side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies (R)	$249.20
59739	Sinogram or fistulogram, one or more regions, with or without preliminary plain films and with preparation and contrast injection (R)	$165.40
59751	Arthrography, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection (R)	$318.10
59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection (R)	$485.50
59763	Air insufflation during video fluoroscopic imaging including associated consultation (R)	$294.70
	Angiography	
59970	Angiography or digital subtraction angiography, or both, with fluoroscopy and image acquisition, using a mobile image intensifier, including any preliminary plain films, preparation and contrast injection one or more regions (R) (H) (Anaes.)	$372.40
60000	Digital subtraction angiography, examination of head and neck with or without arch aortography 1 to 3 data acquisition runs (R) (H) (Anaes.)	$1,244.80
60003	Digital subtraction angiography, examination of head and neck with or without arch aortography 4 to 6 data acquisition runs (R) (H) (Anaes.)	$1,936.70

Item No.	Description	Max Fee (excl. GST)
60006	Digital subtraction angiography, examination of head and neck with or without arch aortography 7 to 9 data acquisition runs (R) (H) (Anaes.)	$2,585.70
60009	Digital subtraction angiography, examination of head and neck with or without arch aortography 10 or more data acquisition runs (R) (H) (Anaes.)	$3,076.10
60012	Digital subtraction angiography, examination of thorax 1 to 3 data acquisition runs (R) (H) (Anaes.)	$1,328.20
60015	Digital subtraction angiography, examination of thorax 4 to 6 data acquisition runs (R) (H) (Anaes.)	$1,831.00
60018	Digital subtraction angiography, examination of thorax 7 to 9 data acquisition runs (R) (H) (Anaes.)	$2,650.20
60021	Digital subtraction angiography, examination of thorax 10 or more data acquisition runs (R) (H) (Anaes.)	$3,245.90
60024	Digital subtraction angiography, examination of abdomen 1 to 3 data acquisition runs (R) (H) (Anaes.)	$1,302.50
60027	Digital subtraction angiography, examination of abdomen 4 to 6 data acquisition runs (R) (H) (Anaes.)	$1,847.70
60030	Digital subtraction angiography, examination of abdomen 7 to 9 data acquisition runs (R) (H) (Anaes.)	$2,626.20
60033	Digital subtraction angiography, examination of abdomen 10 or more data acquisition runs (R) (H) (Anaes.)	$3,035.90
60036	Digital subtraction angiography, examination of upper limb or limbs 1 to 3 data acquisition runs (R) (H) (Anaes.)	$1,243.50
60039	Digital subtraction angiography, examination of upper limb or limbs 4 to 6 data acquisition runs (R) (H) (Anaes.)	$1,831.00
60042	Digital subtraction angiography, examination of upper limb or limbs 7 to 9 data acquisition runs (R) (H) (Anaes.)	$2,611.00
60045	Digital subtraction angiography, examination of upper limb or limbs 10 or more data acquisition runs (R) (H) (Anaes.)	$3,062.90
60048	Digital subtraction angiography, examination of lower limb or limbs 1 to 3 data acquisition runs (R) (H) (Anaes.)	$1,244.30
60051	Digital subtraction angiography, examination of lower limb or limbs 4 to 6 data acquisition runs (R) (H) (Anaes.)	$1,854.30
60054	Digital subtraction angiography, examination of lower limb or limbs 7 to 9 data acquisition runs (R) (H) (Anaes.)	$2,626.20
60057	Digital subtraction angiography, examination of lower limb or limbs 10 or more data acquisition runs (R) (H) (Anaes.)	$3,101.50
60060	Digital subtraction angiography, examination of aorta and lower limb or limbs 1 to 3 data acquisition runs (R) (H) (Anaes.)	$1,255.30
60063	Digital subtraction angiography, examination of aorta and lower limb or limbs 4 to 6 data acquisition runs (R) (H) (Anaes.)	$1,833.40
60066	Digital subtraction angiography, examination of aorta and lower limb or limbs 7 to 9 data acquisition runs (R) (H) (Anaes.)	$2,628.90
60069	Digital subtraction angiography, examination of aorta and lower limb or limbs 10 or more data acquisition runs (R) (H) (Anaes.)	$3,042.80
60072	Selective arteriography or selective venography by digital subtraction angiography technique one vessel (NR) (H) (Anaes.)	$106.60
60075	Selective arteriography or selective venography by digital subtraction angiography technique 2 vessels (NR) (H) (Anaes.)	$212.10
60078	Selective arteriography or selective venography by digital subtraction angiography technique 3 or more vessels (NR) (H) (Anaes.)	$322.50
	Fluoroscopic examination	
60500	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (H) (Anaes.)	$98.30
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R)	$76.70
60506	Fluoroscopy, using a mobile image intensifier, that: (a) lasts less than 1 hour; and (b) is in conjunction with a surgical procedure; not being a service associated with a service to which another item in this Group applies (R) (H)	$142.00
60509	Fluoroscopy, using a mobile image intensifier, that: (a) lasts 1 hour or more; and (b) is in conjunction with a surgical procedure; not being a service associated with a service to which another item in this Group applies (R) (H)	$232.80

Item No.	Description	Max Fee (excl. GST)
	Preparation for radiological procedure	
60918	Arteriography (peripheral) or phlebography one vessel, when used in association with a service to which item 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.)	$104.40
60927	Selective arteriogram or phlebogram, when used in association with a service to which item 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.)	$85.20
	Interventional techniques	
61109	Fluoroscopy in an angiography suite with image intensification, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this Group applies (R) (H)	$607.80
GROUP I4—NUCLEAR MEDICINE IMAGING		
61310	Myocardial infarct avid study (R)	$772.30
61313	Gated cardiac blood pool study, (equilibrium) (R)	$639.80
61314	Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R)	$893.40
61321	Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses a single rest technetium 99m (Tc 99m) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61325, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older a service to which this item, or item 61325, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months (R)	$698.80
61324	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61325, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61325	Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses: (i) an initial rest study followed by a redistribution study on the same day; and (ii) a thallous chloride 201 (Tl 201) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older: (i) a service to which item 61321, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months; and (ii) the service is applicable only twice each 24 months (R)	$698.80
61328	Lung perfusion study (R)	$467.60
61329	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61333	Lung ventilation study using Galligas and lung perfusion study using gallium-68 macro aggregated albumin (68Ga-MAA), with PET, if the service is performed because the service to which item 61348 applies cannot be performed due to unavailability of technetium-99m (R)	$927.90
61336	Cerebral study, with PET, if the service is performed because the service to which item 61402 applies cannot be performed due to unavailability of technetium-99m (R)	$1,266.40

Item No.	Description	Max Fee (excl. GST)
61340	Lung ventilation study using aerosol, technegas or xenon gas (R)	$498.90
61341	Bone study whole body with PET, with delayed imaging when undertaken, if the service is performed because the services to which item 61421 or 61425 apply cannot be performed due to unavailability of technetium-99m (R)	$1,257.40
61345	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414 applies (R); and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R)	$913.30
61349	Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (d) the service is requested by a specialist or a consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730 or 61410 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61410, applies has not been provided to the patient in the previous 12 months (R)	$2,085.90
61353	Liver and spleen study (colloid) (R)	$846.40
61356	Red blood cell spleen or liver study (R)	$822.50
61357	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which items 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61394, 61398, 61406, or 61414, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61360	Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R)	$817.90
61361	Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R)	$944.70
61364	Bowel haemorrhage study (R)	$1,020.70
61368	Meckel s diverticulum study (R)	$483.00
61369	Indium-labelled octreotide study (including single photon emission tomography when undertaken), if: (a) a gastro-entero-pancreatic endocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is to exclude additional disease sites (R)	$4,063.20
61372	Salivary study (R)	$451.20
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R)	$986.80
61376	Oesophageal clearance study (R)	$290.30
61381	Gastric emptying study, using single tracer (R)	$1,159.00

Item No.	Description	Max Fee (excl. GST)
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R)	$1,259.30
61384	Radionuclide colonic transit study (R)	$1,386.00
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R)	$671.90
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R)	$870.90
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	$778.80
61390	Renal study with diuretic administration after a baseline study (R)	$829.00
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)	$1,305.70
61394	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61398, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61397	Cystoureterogram (R)	$504.80
61398	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the services is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R)	$1,320.20
61406	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61409	Cerebro-spinal fluid transport study using technetium 99m, with imaging on 2 or more separate occasions (R)	$1,879.80
61410	Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (d) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies; and (f) if the patient is 17 years or older a service to which item 61349 applies has not been provided to the patient in the previous 12 months	$2,085.90
61413	Cerebro spinal fluid shunt patency study (R)	$494.10

Item No.	Description	Max Fee (excl. GST)
61414	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61406 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398 or 61406, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61421	Bone study whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$1,021.80
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)	$1,286.30
61426	Whole body study using iodine (R)	$1,122.80
61429	Whole body study using gallium (R)	$1,192.90
61430	Whole body study using gallium, with single photon emission tomography (R)	$1,401.90
61433	Whole body study using cells labelled with technetium (R)	$1,006.90
61434	Whole body study using cells labelled with technetium, with single photon emission tomography (R)	$1,308.00
61438	Whole body study using thallium (R)	$1,480.80
61441	Bone marrow study whole body using technetium labelled bone marrow agents (R)	$996.70
61442	Whole body study, using gallium with single photon emission tomography of 2 or more body regions acquired separately (R)	$1,648.10
61445	Bone marrow study localised using technetium labelled agent (R)	$621.60
61446	Regional scintigraphic study, using an approved bone scanning agent, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R)	$691.90
61449	Regional scintigraphic study, using an approved bone scanning agent and single photon emission tomography, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R)	$948.10
61450	Localised study using gallium (R)	$854.70
61453	Localised study using gallium, with single photon emission tomography (R)	$1,078.60
61454	Localised study using cells labelled with technetium (R)	$713.10
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R)	$948.50
61461	Localised study using thallium (R)	$1,064.10
61462	Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R)	$271.10
61466	Cerebro-spinal fluid transport study using indium-111, with imaging on 2 or more separate occasions (R)	$8,918.00
61469	Lymphoscintigraphy (R)	$701.30
61473	Thyroid study (R)	$355.50
61480	Parathyroid study (R)	$786.90
61485	Adrenal study, with single photon emission tomography (R)	$2,185.50
61495	Tear duct study (R)	$483.00
61499	Particle perfusion study (infra arterial) or Le Veen shunt study (R)	$534.50
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and performed in association with a service to which an item in Subgroup 1 or 2 of Group I4 applies (R)	$210.30
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)	$1,921.00
61527	Whole body study using PET, if the service is performed because the services to which items 61429, 61430, 61442, 61450 or 61453 apply cannot be performed due to unavailability of gallium-67 (R)	$1,535.10

Item No.	Description	Max Fee (excl. GST)
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)	$1,921.00
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)	$1,816.20
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)	$1,921.00
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)	$2,013.90
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R)	$1,850.50
61563	Whole body prostate-specific membrane antigen PET study performed for the initial staging of intermediate to high-risk prostate adenocarcinoma, for a previously untreated patient who is considered suitable for locoregional therapy with curative intent Applicable once per lifetime (R)	$2,652.60
61564	Whole body prostate-specific membrane antigen PET study performed for the restaging of recurrent prostate adenocarcinoma, for a patient who: (a) has undergone prior locoregional therapy; and (b) is considered suitable for further locoregional therapy to determine appropriate therapeutic pathways and timing of treatment initiation Applicable twice per lifetime (R)	$2,652.60
61565	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy. (R)	$1,921.00
61571	Whole body FDG PET study, for the further primary staging of patients with histologically proven carcinoma of the uterine cervix, at FIGO stage IB2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative intent. (R)	$1,921.00
61575	Whole body FDG PET study, for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent. (R)	$1,855.60
61577	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R).	$1,921.00
61598	Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (R).	$1,921.00
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).	$1,921.00
61610	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R).	$1,921.00
61612	Whole body FDG PET study for the initial staging of cancer, for a patient who is considered suitable for active therapy, if: (a) the cancer is a typically FDG-avid cancer; and (b) there is at least 10% likelihood that a PET study result will inform a significant change in management for the patientApplicable once per cancer diagnosis (R)	$1,944.60
61614	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent cancer in a patient who is undergoing, or is suitable for, active therapy, if the cancer is a typically FGD-avid cancer (R)	$1,429.50
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R)	$1,855.60
61622	Whole body FDG PET study to assess response to first line therapy either during treatment or within three months of completing definitive first line treatment for Hodgkin or non-Hodgkin lymphoma (R)	$1,921.00
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R)	$1,921.00
61632	Whole body FDG PET study to assess response to second-line chemotherapy if haemopoietic stem cell transplantation is being considered for Hodgkin or non-Hodgkin lymphoma (R)	$1,855.60
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)	$2,013.90
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)	$2,013.90
61647	Whole body 68Ga DOTA peptide PET study, if: (a) a gastro entero pancreatic neuroendocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro entero pancreatic neuroendocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is for excluding additional disease sites (R)	$1,941.70

Item No.	Description	Max Fee (excl. GST)
61650	LeukoScan study of the long bones and feet for suspected osteomyelitis, if: (a) the patient does not have access to ex vivo white blood cell scanning; and (b) the patient is not being investigated for other sites of infection (R)	$1,921.00
	Nuclear medicine—non PET	
61310	Myocardial infarct avid study (R)	$772.30
61313	Gated cardiac blood pool study, (equilibrium) (R)	$639.80
61314	Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R)	$893.40
61321	Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses a single rest technetium 99m (Tc 99m) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61325, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older a service to which this item, or item 61325, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months (R)	$698.80
61324	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61325, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61325	Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses: (i) an initial rest study followed by a redistribution study on the same day; and (ii) a thallous chloride 201 (Tl 201) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older: (i) a service to which item 61321, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months; and (ii) the service is applicable only twice each 24 months (R)	$698.80
61328	Lung perfusion study (R)	$467.60
61329	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61340	Lung ventilation study using aerosol, technegas or xenon gas (R)	$498.90
61345	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414 applies (R); and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90

Item No.	Description	Max Fee (excl. GST)
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R)	$913.30
61349	Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (d) the service is requested by a specialist or a consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730 or 61410 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61410, applies has not been provided to the patient in the previous 12 months (R)	$2,085.90
61353	Liver and spleen study (colloid) (R)	$846.40
61356	Red blood cell spleen or liver study (R)	$822.50
61357	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which items 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61394, 61398, 61406, or 61414, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61360	Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R)	$817.90
61361	Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R)	$944.70
61364	Bowel haemorrhage study (R)	$1,020.70
61368	Meckel s diverticulum study (R)	$483.00
61369	Indium-labelled octreotide study (including single photon emission tomography when undertaken), if: (a) a gastro-entero-pancreatic endocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is to exclude additional disease sites (R)	$4,063.20
61372	Salivary study (R)	$451.20
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R)	$986.80
61376	Oesophageal clearance study (R)	$290.30
61381	Gastric emptying study, using single tracer (R)	$1,159.00
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R)	$1,259.30
61384	Radionuclide colonic transit study (R)	$1,386.00
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R)	$671.90
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R)	$870.90
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	$778.80
61390	Renal study with diuretic administration after a baseline study (R)	$829.00
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)	$1,305.70

Item No.	Description	Max Fee (excl. GST)
61394	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61398, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61397	Cystoureterogram (R)	$504.80
61398	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the services is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R)	$1,320.20
61406	Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414, applies has not been provided to the patient in the previous 24 months (R)	$2,085.90
61409	Cerebro-spinal fluid transport study using technetium 99m, with imaging on 2 or more separate occasions (R)	$1,879.80
61410	Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (d) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies; and (f) if the patient is 17 years or older a service to which item 61349 applies has not been provided to the patient in the previous 12 months	$2,085.90
61413	Cerebro spinal fluid shunt patency study (R)	$494.10
61414	Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61406 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398 or 61406, applies has not been provided to the patient in the previous 24 months (R)	$1,387.30
61421	Bone study whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$1,021.80

Item No.	Description	Max Fee (excl. GST)
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)	$1,286.30
61426	Whole body study using iodine (R)	$1,122.80
61429	Whole body study using gallium (R)	$1,192.90
61430	Whole body study using gallium, with single photon emission tomography (R)	$1,401.90
61433	Whole body study using cells labelled with technetium (R)	$1,006.90
61434	Whole body study using cells labelled with technetium, with single photon emission tomography (R)	$1,308.00
61438	Whole body study using thallium (R)	$1,480.80
61441	Bone marrow study whole body using technetium labelled bone marrow agents (R)	$996.70
61442	Whole body study, using gallium with single photon emission tomography of 2 or more body regions acquired separately (R)	$1,648.10
61445	Bone marrow study localised using technetium labelled agent (R)	$621.60
61446	Regional scintigraphic study, using an approved bone scanning agent, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R)	$691.90
61449	Regional scintigraphic study, using an approved bone scanning agent and single photon emission tomography, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R)	$948.10
61450	Localised study using gallium (R)	$854.70
61453	Localised study using gallium, with single photon emission tomography (R)	$1,078.60
61454	Localised study using cells labelled with technetium (R)	$713.10
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R)	$948.50
61461	Localised study using thallium (R)	$1,064.10
61462	Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R)	$271.10
61466	Cerebro-spinal fluid transport study using indium-111, with imaging on 2 or more separate occasions (R)	$8,918.00
61469	Lymphoscintigraphy (R)	$701.30
61473	Thyroid study (R)	$355.50
61480	Parathyroid study (R)	$786.90
61485	Adrenal study, with single photon emission tomography (R)	$2,185.50
61495	Tear duct study (R)	$483.00
61499	Particle perfusion study (infra arterial) or Le Veen shunt study (R)	$534.50
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and performed in association with a service to which an item in Subgroup 1 or 2 of Group I4 applies (R)	$210.30
61650	LeukoScan study of the long bones and feet for suspected osteomyelitis, if: (a) the patient does not have access to ex vivo white blood cell scanning; and (b) the patient is not being investigated for other sites of infection (R)	$1,921.00
GROUP I5—MAGNETIC RESONANCE IMAGING		
	Scan of head—for specified conditions	
63001	MRI scan of head (including MRA, if performed) for tumour of the brain or meninges (R) (Contrast) (Anaes.)	$908.60
63004	MRI scan of head (including MRA, if performed) for inflammation of brain or meninges (R) (Contrast) (Anaes.)	$908.60
63007	MRI scan of head (including MRA, if performed) for skull base or orbital tumour (R) (Contrast) (Anaes.)	$908.60
63010	MRI scan of head (including MRA, if performed) for stereotactic scan of brain, with fiducials in place, for the sole purpose of allowing planning for stereotactic neurosurgery (R) (Contrast) (Anaes.)	$764.50

Item No.	Description	Max Fee (excl. GST)
63040	MRI scan of head (including MRA, if performed) for acoustic neuroma (R) (Contrast) (Anaes.)	$742.90
63043	MRI scan of head (including MRA, if performed) for pituitary tumour (R) (Contrast) (Anaes.)	$778.00
63046	MRI scan of head (including MRA, if performed) for toxic or metabolic or ischaemic encephalopathy (R) (Contrast) (Anaes.)	$908.60
63049	MRI scan of head (including MRA, if performed) for demyelinating disease of the brain (R) (Contrast) (Anaes.)	$908.60
63052	MRI scan of head (including MRA, if performed) for congenital malformation of the brain or meninges (R) (Contrast) (Anaes.)	$908.60
63055	MRI scan of head (including MRA, if performed) for venous sinus thrombosis (R) (Contrast) (Anaes.)	$908.60
63058	MRI scan of head (including MRA, if performed) for head trauma (R) (Contrast) (Anaes.)	$908.60
63061	MRI scan of head (including MRA, if performed) for epilepsy (R) (Contrast) (Anaes.)	$908.60
63064	MRI scan of head (including MRA, if performed) for stroke (R) (Contrast) (Anaes.)	$908.60
63067	MRI scan of head (including MRA, if performed) for carotid or vertebral artery dissection (R) (Contrast) (Anaes.)	$908.60
63070	MRI scan of head (including MRA, if performed) for intracranial aneurysm (R) (Contrast) (Anaes.)	$908.60
63073	MRI scan of head (including MRA, if performed) for intracranial arteriovenous malformation (R) (Contrast) (Anaes.)	$908.60
	Scan of head and neck vessels—for specified conditions	
63101	MRI and MRA of extracranial or intracranial circulation (or both) scan of head and neck vessels for stroke (R) (Contrast) (Anaes.)	$1,082.90
	Scan of head and cervical spine—for specified conditions	
63111	MRI scan of head and cervical spine (including MRA, if performed) for tumour of the central nervous system or meninges (R) (Contrast) (Anaes.)	$1,082.90
63114	MRI scan of head and cervical spine (including MRA, if performed) for inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.)	$1,082.90
63125	MRI scan of head and cervical spine (including MRA, if performed) for demyelinating disease of the central nervous system (R) (Contrast) (Anaes.)	$1,082.90
63128	MRI scan of head and cervical spine (including MRA, if performed) for congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.)	$1,082.90
63131	MRI scan of head and cervical spine (including MRA, if performed) for syrinx (congenital or acquired) (R) (Contrast) (Anaes.)	$1,082.90
	Scan of spine—one region or two contiguous regions—for infection or tumour	
63151	MRI scan of one region or 2 contiguous regions of the spine for infection (R) (Contrast) (Anaes.)	$778.00
63154	MRI scan of one region or 2 contiguous regions of the spine for tumour (R) (Contrast) (Anaes.)	$778.00
	Scan of spine—one region or two contiguous regions—for other conditions	
63161	MRI scan of one region or 2 contiguous regions of the spine for demyelinating disease (R) (Contrast) (Anaes.)	$778.00
63164	MRI scan of one region or 2 contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.)	$778.00
63167	MRI scan of one region or 2 contiguous regions of the spine for myelopathy (R) (Contrast) (Anaes.)	$778.00
63170	MRI scan of one region or 2 contiguous regions of the spine for syrinx (congenital or acquired) (R) (Contrast) (Anaes.)	$778.00
63173	MRI scan of one region or 2 contiguous regions of the spine for cervical radiculopathy (R) (Contrast) (Anaes.)	$778.00
63176	MRI scan of one region or 2 contiguous regions of the spine for sciatica (R) (Contrast) (Anaes.)	$778.00
63179	MRI scan of one region or 2 contiguous regions of the spine for spinal canal stenosis (R) (Contrast) (Anaes.)	$778.00
63182	MRI scan of one region or 2 contiguous regions of the spine for previous spinal surgery (R) (Contrast) (Anaes.)	$778.00
63185	MRI scan of one region or 2 contiguous regions of the spine for trauma (R) (Anaes.)	$778.00
	Scan of spine—three contiguous regions or two non-contiguous regions—for infection or tumour	
63201	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for infection (R) (Contrast) (Anaes.)	$995.20
63204	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for tumour (R) (Contrast) (Anaes.)	$995.20

Item No.	Description	Max Fee (excl. GST)
	Scan of spine—three contiguous regions or two non-contiguous regions—for other conditions	
63219	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for demyelinating disease (R) (Contrast) (Anaes.)	$995.20
63222	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.)	$995.20
63225	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for myelopathy (R) (Contrast) (Anaes.)	$995.20
63228	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for syrinx (congenital or acquired) (R) (Contrast) (Anaes.)	$995.20
63231	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for cervical radiculopathy (R) (Contrast) (Anaes.)	$995.20
63234	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for sciatica (R) (Contrast) (Anaes.)	$995.20
63237	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for spinal canal stenosis (R) (Contrast) (Anaes.)	$995.20
63240	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for previous spinal surgery (R) (Contrast) (Anaes.)	$995.20
63243	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for trauma (R) (Anaes.)	$995.20
	Scan of cervical spine and brachial plexus—for specified conditions	
63271	MRI scan of cervical spine and brachial plexus for tumour (R) (Contrast) (Anaes.)	$1,082.90
63274	MRI scan of cervical spine and brachial plexus for trauma (R) (Contrast) (Anaes.)	$1,082.90
63277	MRI scan of cervical spine and brachial plexus for cervical radiculopathy (R) (Contrast) (Anaes.)	$1,082.90
63280	MRI scan of cervical spine and brachial plexus for previous surgery (R) (Contrast) (Anaes.)	$1,082.90
	Scan of musculoskeletal system—for tumour, infection or osteonecrosis	
63301	MRI scan of musculoskeletal system for tumour arising in bone or musculoskeletal system, excluding tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.)	$870.60
63304	MRI scan of musculoskeletal system for infection arising in bone or musculoskeletal system, excluding infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.)	$870.60
63307	MRI scan of musculoskeletal system for osteonecrosis (R) (Contrast) (Anaes.)	$870.60
	Scan of musculoskeletal system—for joint derangement	
63322	MRI scan of musculoskeletal system for derangement of hip or its supporting structures (R) (Contrast) (Anaes.)	$908.90
63325	MRI scan of musculoskeletal system for derangement of shoulder or its supporting structures (R) (Contrast) (Anaes.)	$908.90
63328	MRI scan of musculoskeletal system for derangement of knee or its supporting structures (R) (Contrast) (Anaes.)	$908.90
63331	MRI scan of musculoskeletal system for derangement of ankle or foot (or both) or its supporting structures (R) (Contrast) (Anaes.)	$908.90
63334	MRI scan of musculoskeletal system for derangement of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.)	$764.50
63337	MRI scan of musculoskeletal system for derangement of wrist or hand (or both) or its supporting structures (R) (Contrast) (Anaes.)	$995.20
63340	MRI scan of musculoskeletal system for derangement of elbow or its supporting structures (R) (Contrast) (Anaes.)	$908.90
	Scan of musculoskeletal system—for Gaucher disease	
63361	MRI scan of musculoskeletal system for Gaucher disease (R) (Anaes.)	$908.90
	Scan of cardiovascular system—for specified conditions	
63385	MRI scan of cardiovascular system for congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.)	$995.20
63388	MRI scan of cardiovascular system for tumour of the heart or a great vessel (R) (Contrast) (Anaes.)	$995.20
63390	MRI scan of cardiovascular system for assessment of myocardial structure, function and characterisation, if the request for the scan indicates that the patient has: (a) acute onset (less than 3 months) heart failure caused by suspected myocarditis which would otherwise require endomyocardial biopsy to confirm the diagnosis of myocarditis; or (b) unexplained arrhythmia caused by suspected myocarditis which would otherwise require endomyocardial biopsy to confirm the diagnosis of myocarditis; or (c) suspected drug-induced myocarditis, if the results from all of the following examinations are inconclusive to form a diagnosis: (i) troponin; (ii) chest X-ray; (iii) transthoracic echocardiogram. (R) (Contrast) (Anaes.)	$903.20

Item No.	Description	Max Fee (excl. GST)
63391	MRI scan of cardiovascular system for abnormality of thoracic aorta (R) (Contrast) (Anaes.)	$908.90
63395	MRI scan of cardiovascular system for assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end diastolic and end systolic volumes, ejection fraction and BSA indexed values;if the request for the scan indicates that: (d) the patient presented with symptoms consistent with arrhythmogenic right ventricular cardiomyopathy (ARVC); or (e) investigative findings in relation to the patient are consistent with ARVC (R) (Contrast) (Anaes.)	$1,905.40
63397	MRI scan of cardiovascular system for assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end diastolic and end systolic volumes, ejection fraction and BSA indexed values;if the request for the scan indicates that the patient: (d) is asymptomatic; and (e) has one or more first degree relatives diagnosed with confirmed arrhythmogenic right ventricular cardiomyopathy (ARVC) (R) (Contrast) (Anaes.)	$1,905.40
	Magnetic resonance angiography—scan of cardiovascular system—for specified conditions	
63401	MRA if the request for the scan specifically identifies the clinical indication for the scan scan of cardiovascular system for vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.)	$908.90
63404	MRA if the request for the scan specifically identifies the clinical indication for the scan scan of cardiovascular system for obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.)	$908.90
	Magnetic resonance angiography—for specified conditions—person under the age of 16 years	
63416	MRA scan of person under the age of 16 for the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.)	$908.90
	Magnetic resonance imaging—person under the age of 16 years ?for physeal fusion or Gaucher disease	
63425	MRI scan of person under the age of 16 for post inflammatory or post traumatic physeal fusion (R) (Anaes.)	$908.90
63428	MRI scan of person under the age of 16 for Gaucher disease (R) (Anaes.)	$908.90
	Magnetic resonance imaging—person under the age of 16 years ?for other conditions	
63440	MRI scan of person under the age of 16 for pelvic or abdominal mass (R) (Contrast) (Anaes.)	$908.90
63443	MRI scan of person under the age of 16 for mediastinal mass (R) (Contrast) (Anaes.)	$908.90
63446	MRI scan of person under the age of 16 for congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.)	$908.90
	Scan of body—for specified conditions	
63461	MRI scan of the body for adrenal mass in a patient with a malignancy that is otherwise resectable (R) (Anaes.)	$775.30
63464	MRI scan of both breasts for the detection of cancer in a patient, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient is asymptomatic and is younger than 60 years of age; and (c) the request for the scan identifies that the patient is at high risk of developing breast cancer due to one or more of the following: (i) genetic testing has identified the presence of a high risk breast cancer gene mutation in the patient or in a first degree relative of the patient; (ii) both: (A) one of the patient s first or second degree relatives was diagnosed with breast cancer at age 45 years or younger; and (B) another first or second degree relative on the same side of the patient s family was diagnosed with bone or soft tissue sarcoma at age 45 years or younger; (iii) the patient has a personal history of breast cancer before the age of 50 years; (iv) the patient has a personal history of mantle radiation therapy; (v) the patient has a lifetime risk estimation greater than 30% or a 10 year absolute risk estimation greater than 5% using a clinically relevant risk evaluation algorithm; and (d) the service is not performed in conjunction with item 55076 or 55079 Applicable not more than once in a 12 month period (R) (Contrast) (Anaes.)	$1,513.40
63467	MRI scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service mentioned in item 63464 performed in the previous 12 months (R) (Anaes.)	$1,507.50
63487	MRI scan of both breasts, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (Anaes.)	$1,562.00
63489	MRI scan of one breast, performed in conjunction with a biopsy procedure on that breast and an ultrasound scan of that breast, if: (a) the request for the MRI scan identifies that the patient has a suspicious lesion seen on MRI but not on conventional imaging; and (b) the ultrasound scan is performed immediately before the MRI scan and confirms that the lesion is not amenable to biopsy guided by conventional imaging; and (c) a dedicated breast coil is used (R) (Anaes.)	$2,414.70
63541	Multiparametric MRI scan of the prostate for the detection of cancer, requested by a specialist in the speciality of urology, radiation oncology or medical oncology: (a) if the request for the scan identifies that the patient is suspected of developing prostate cancer: (i) on the basis of a digital rectal examination; or (ii) in the circumstances mentioned in Clause 2.5.9A; and (b) using a standardised image acquisition protocol involving: (i) T2 weighted imaging; and (ii) diffusion weighted imaging; and (iii) (unless contraindicated) dynamic contrast enhancement (R) Note: See explanatory note IN.5.1 for the meaning of Clause 2.5.9 in the descriptor for this item and the claiming limitations. (Anaes.)	$1,002.50

Item No.	Description	Max Fee (excl. GST)
63543	Multiparametric MRI scan of the prostate for the assessment of cancer, requested by a specialist in the speciality of urology, radiation oncology or medical oncology: (a) if the request for the scan identifies that the patient: (i) is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and (ii) is not undergoing, or planning to undergo, treatment for prostate cancer; and (b) using a standardised image acquisition protocol involving: (i) T2 weighted imaging; and (ii) diffusion weighted imaging; and (iii) (unless contraindicated) dynamic contrast enhancement (R) Note: See explanatory note IN.5.2 for claiming restrictions for this item. (Anaes.)	$1,002.50
63547	MRI scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has a breast implant in situ; and (ii) anaplastic large cell lymphoma has been diagnosed (R) (Contrast) (Anaes.)	$1,537.20
63564	Note: the requirements for services provided under item 63564 are detailed under note IN.5.4 MRI whole body scan for the early detection of cancer: (a) requested by a specialist or consultant physician in consultation with a clinical geneticist in a familial cancer or genetic clinic; and (b) the request identifies that the patient has a high risk of developing cancer malignancy due to heritable TP53 - related cancer (hTP53rc) syndrome (R) (Anaes.)	$2,851.70
	Scan of pelvis and upper abdomen—for specified conditions	
63454	MRI scan of the pelvis or abdomen, for a patient who is pregnant, if: (a) the pregnancy is at, or after, 18 weeks gestation; and (b) fetal abnormality is suspected; and (c) an ultrasound has been performed and is provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics; and (d) the diagnosis of fetal abnormality as a result of the ultrasound is indeterminate or requires further examination; and (e) the MRI service is requested by a specialist practising in the specialty of obstetrics (R) (Contrast) (Anaes.)	$2,614.60
63470	MRI scan of the pelvis for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and (b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.)	$908.90
63473	MRI scan of the pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for the scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and (b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.)	$1,346.20
63476	MRI scan of the pelvis for the initial staging, restaging or follow up of rectal cancer, if: (a) a high resolution T2 technique is used; and (b) the request for the scan identifies that the indication is for: (i) the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum); or (ii) the initial assessment of response to chemotherapy or chemoradiotherapy; or (iii) the assessment of possible recurrent tumour after complete response to neoadjuvant therapy, within an active surveillance program; or (iv) the assessment of recurrent disease prior to treatment planning (R) (Contrast) (Anaes.)	$892.30
63549	MRI scan of the pelvis or abdomen, for a patient with a multiple pregnancy, if: (a) the multiple pregnancy is at, or after, 18 weeks gestation; and (b) fetal abnormality is suspected; and (c) an ultrasound has been performed and is provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics; and (d) the diagnosis of fetal abnormality as a result of the ultrasound is indeterminate or requires further examination; and (e) the MRI service is requested by a specialist practising in the specialty of obstetrics (R) (Contrast) (Anaes.)	$3,731.60
63563	MRI scan of the pelvis or abdomen, if the request for the scan identifies that the investigation is for: (a) sub fertility that requires one or more of the following: (i) an investigation of suspected Mullerian duct anomaly seen in pelvic ultrasound or hysterosalpingogram; (ii) an assessment of uterine mass identified on pelvic ultrasound before consideration of surgery; (iii) an investigation of recurrent implantation failure in IVF (2 or more embryo transfer cycles without viable pregnancy); or (b) surgical planning of a patient with known or suspected deep endometriosis involving the bowel, bladder or ureter (or any combination of the bowel, bladder or ureter), where the results of pelvic ultrasound are inconclusive Applicable not more than once in a 2 year period (R) (Contrast) (Anaes.)	$835.80
63740	MRI scan to evaluate small bowel Crohn s disease if the service is provided to a patient for: (a) evaluation of disease extent at time of initial diagnosis of Crohn s disease; or (b) evaluation of exacerbation, or suspected complications, of known Crohn s disease; or (c) evaluation of known or suspected Crohn s disease in pregnancy; or (d) assessment of change to therapy in a patient with small bowel Crohn s disease (R) (Contrast)	$982.70
63741	MRI scan with enteroclysis for Crohn s disease if the service is related to item 63740 (R)	$570.00
63743	MRI scan for fistulising perianal Crohn s disease if the service is provided to a patient for: (a) evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn s disease; or (b) assessment of change to therapy of pelvis sepsis and fistulas from Crohn s disease (R) (Contrast)	$866.50
	Scan of body—for suspected hepato-biliary or pancreatic pathology	
63482	MRI scan of pancreas and biliary tree for suspected biliary or pancreatic pathology (R) (Anaes.)	$932.20

Item No.	Description	Max Fee (excl. GST)
63545	MRI - multiphase scans of liver (including delayed imaging, if performed) with a contrast agent, for characterisation, or staging where surgical resection or interventional techniques are under consideration, if: (a) the patient has a confirmed extra hepatic primary malignancy (other than hepatocellular carcinoma); and (b) computed tomography is negative or inconclusive for hepatic metastatic disease; and (c) the identification of liver metastases would change the patient s treatment planning Applicable not more than once in a 12 month period (R) (Contrast) (Anaes.)	$1,198.50
63546	MRI multiphase scans of the liver (including delayed imaging, if performed) with a contrast agent, for diagnosis or staging, if: (a) the patient has: (i) known or suspected hepatocellular carcinoma; and (ii) chronic liver disease that has been confirmed by a specialist or consultant physician; and (b) the patient s liver function has been identified as Child Pugh or B; and (c) the patient has an identified hepatic lesion over 10mm in diameter.For any particular patient applicable not more than once in a 12 month period (R) (Contrast) (Anaes.)	$1,198.50
	Modifying items	
63491	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with Clause 2.5.1; and (b) the item for the service includes in its description (Contrast) ; and (c) the service is performed using a contrast agent	$103.70
63494	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with Clause 2.5.1; and (b) the service is performed using intravenous or intra muscular sedation	$99.30
63496	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. MRI service to which item 63545 or 63546 applies if: (a) the service is performed on a person under the supervision of an eligible provider; and (b) the service is performed using an hepatobiliary specific contrast agent	$544.90
63497	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with Clause 2.5.1; and (b) the service is performed under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic	$362.40
63498	MRI service to which item 63501, 63502, 63504 or 63505 applies, if the service is performed on a person using intravenous or intra muscular sedation	$102.80
63499	MRI service to which item 63501, 63502, 63504 or 63505 applies, if the service is performed on a person under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic (H)	$360.40
	Magnetic resonance imaging—PIP breast implant	
63501	MRI scan of one or both breasts for the evaluation of implant integrity, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan confirms a loss of integrity of the implant (R)	$1,149.40
63502	MRI scan of one or both breasts for the evaluation of implant integrity, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan does not demonstrate a loss of integrity of the implant (R)	$1,149.40
63504	MRI scan of one or both breasts for the evaluation of implant integrity, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan confirms a loss of integrity of the implant (R)	$1,149.40
63505	MRI scan of one or both breasts for the evaluation of implant integrity, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan does not demonstrate a loss of integrity of the implant (R)	$1,149.40
	Scan of body—person under the age of 16 years ?general practice requests	
63507	MRI scan of head for a patient under 16 years if the service is for: (a) an unexplained seizure; or (b) an unexplained headache if significant pathology is suspected; or (c) paranasal sinus pathology that has not responded to conservative therapy (R) (Contrast) (Anaes.)	$908.60
63510	MRI scan of spine following radiographic examination for a patient under 16 years if the service is for: (a) significant trauma; or (b) unexplained neck or back pain with associated neurological signs; or (c) unexplained back pain if significant pathology is suspected (R) (Contrast) (Anaes.)	$995.20
63513	MRI scan of knee for internal joint derangement for a patient under 16 years (R) (Contrast) (Anaes.)	$908.90

Item No.	Description	Max Fee (excl. GST)
63516	MRI scan of hip following radiographic examination for a patient under 16 years if any of the following is suspected: (a) septic arthritis; (b) slipped capital femoral epiphysis; (c) Perthes disease (R) (Contrast) (Anaes.)	$908.90
63519	MRI scan of elbow following radiographic examination for a patient under 16 years if a significant fracture or avulsion injury, which would change the way in which the patient is managed, is suspected (R) (Contrast) (Anaes.)	$908.90
63522	MRI scan of wrist following radiographic examination for a patient under 16 years if a scaphoid fracture is suspected (R) (Contrast) (Anaes.)	$995.20
	Scan of body—person over the age of 16 years ?general practice requests	
63551	MRI - scan of head for a patient 16 years or older, after a request by a medical practitioner (other than a specialist or consultant physician), for any of the following: (a) unexplained seizure (s); (b) unexplained chronic headache with suspected intracranial pathology (R) (Contrast) (Anaes.)	$893.40
63554	MRI - scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical radiculopathy (R) (Contrast) (Anaes.)	$794.10
63557	MRI - scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical spinal trauma (R) (Contrast) (Anaes.)	$1,091.80
63560	MRI - scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient 16 to 49 years with: (a) inability to extend the knee suggesting the possibility of acute meniscal tear; or (b) clinical findings suggesting acute anterior cruciate ligament tear (R) (Contrast) (Anaes.)	$893.40
GROUP P1—HAEMATOLOGY		
65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests	$16.00
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072	$20.70
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 sets of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072	$34.30
65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests	$20.60
65075	Haemolysis or metabolic enzymes - assessment by: (a) erythrocyte autohaemolysis test; or (b) erythrocyte osmotic fragility test; or (c) sugar water test; or (d) G-6-P D (qualitative or quantitative) test; or (e) pyruvate kinase (qualitative or quantitative) test; or (f) acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests 1 or more tests	$105.60
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	$178.20
65079	Tests described in item 65078 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$178.20
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	$191.30
65082	Tests described in item 65081 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$191.30
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	$330.00
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070	$164.20
65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen)	$22.40
65093	Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed)	$43.50
65096	Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected; and (b) (if performed) any test described in item 65060 or 65070	$81.10

Item No.	Description	Max Fee (excl. GST)
65099	Compatibility tests by crossmatch - all tests performed on any 1 day for up to 6 units, including: (a) direct testing of donor red cells from each unit against the serum of the patient by one or more accepted crossmatching techniques; and (b) all grouping checks of the patient and donor; and (c) examination for antibodies, and if necessary identification of any antibodies detected; and (d) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5)	$218.70
65102	Compatibility tests by crossmatch - all tests performed on any 1 day in excess of 6 units, including: (a) direct testing of donor red cells from each unit against serum of the patient by one or more accepted crossmatching techniques; and (b) all grouping checks of the patient and donor; and (c) examination for antibodies, and if necessary identification of any antibodies detected; and (d) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5)	$326.10
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)	$220.90
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)	$325.30
65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy - 1 release.	$26.10
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.	$26.10
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected)	$47.30
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies	$18.10
65117	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test)	$40.10
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	$27.20
65123	2 tests described in item 65120	$41.20
65126	3 tests described in item 65120	$56.10
65129	4 or more tests described in item 65120	$71.20
65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65175, 65176, 65177, 65178 and 65179 apply	$51.20
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	$51.20
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	$111.90
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test	$76.50
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)	$140.30
65153	2 tests described in item 65150 (Item is subject to rule 6)	$280.60
65156	3 or more tests described in item 65150 (Item is subject to rule 6)	$420.90
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)	$140.30
65158	Tests described in item 65150, other than that described in 65157, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18)	$140.30
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test	$140.30
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test)	$21.10
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162	$69.30

Item No.	Description	Max Fee (excl. GST)
65166	A test described in item 65165 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$68.20
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	$51.20
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)	$51.20
65176	2 tests described in item 65175 (Item is subject to rule 6)	$96.10
65177	3 tests described in item 65175 (Item is subject to rule 6)	$142.50
65178	4 tests described in item 65175 (Item is subject to rule 6)	$188.50
65179	5 tests described in item 65175 (Item is subject to rule 6)	$234.30
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)	$51.20
65181	A test described in item 65175, if rendered by a receiving APP, if one or more tests described in the item have been rendered by the referring APP - one test (Item is subject to rule 6 and 18)	$46.20
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	$19.30
66503	2 tests described in item 66500	$22.90
66506	3 tests described in item 66500	$27.20
66509	4 tests described in item 66500	$31.20
66512	5 or more tests described in item 66500	$35.20
66517	Quantitation of bile acids in blood in pregnancy. Applicable not more than 3 times in a pregnancy.	$39.90
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	$40.10
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	$80.70
66522	Faecal calprotectin test for the diagnosis of inflammatory bowel disease, if all the following apply: the patient is under 50 years of age; the patient has gastrointestinal symptoms suggestive of inflammatory or functional bowel disease of more than 6 weeks duration; infectious causes have been excluded; the likelihood of malignancy has been assessed as low; no relevant clinical alarms are present	$159.30
66523	Faecal calprotectin test for the diagnosis of inflammatory bowel disease, if all the following apply: the results of a service to which item 66522 applies were inconclusive for the patient (that is, the results showed a faecal calprotectin level of more than 50 g/g but not more than 100 g/g); the patient has ongoing gastrointestinal symptoms suggestive of inflammatory or functional bowel disease; the service is requested by a specialist or consultant physician practising as a specialist gastroenterologist; the request indicates that an endoscopic examination is not initially required; no relevant clinical alarms are present	$159.30
66525	Faecal calprotectin test for the management of a symptomatic patient with diagnosed inflammatory bowel disease, requested by or on behalf of a specialist or consultant physician	$112.50
66536	Quantitation of hdl cholesterol	$21.80
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5mmol/L and triglyceride >4.0mmol/L or in the diagnosis of types III and IV hyperlipidaemia - (Item is subject to rule 25)	$63.30
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; and (b) at least 2 measurements of blood glucose; and (c) (if performed) any test described in item 66695	$37.80
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	$32.00
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)	$40.40

Item No.	Description	Max Fee (excl. GST)
66551	Quantitation of glycated haemoglobin performed in the management of established diabetes (See para PR.2.2 of explanatory notes to this Category)	$34.00
66554	Quantitation of glycated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - including a service in item 66551 (if performed) - (Item is subject to rule 25)	$34.00
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period	$19.70
66560	Microalbumin - quantitation in urine	$40.00
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests	$48.90
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	$70.50
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day	$84.20
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day	$103.60
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day	$119.50
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day	$139.80
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day	$156.90
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test	$19.70
66586	Quantification of BNP or NT-proBNP testing in a patient with diagnosed pulmonary arterial hypertension to monitor for disease progression Applicable 4 times in any 12-month period	$101.30
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	$94.00
66590	Calculus, analysis of 1 or more	$61.50
66593	Ferritin - quantitation, except if requested as part of iron studies	$36.40
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin	$65.90
66605	Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests	$60.60
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)	$60.60
66607	Vitamins - quantitation of vitamins a or e in blood, urine or other body fluid - 1 or more tests within a 6 month period	$149.80
66610	A test described in item 66607 if rendered by a receiving app - 1 or more tests	$148.40
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	$82.20
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)	$47.70
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests	$40.00
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests	$40.00
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests	$40.00
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests	$97.00
66639	A test described in item 66638 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$57.80
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	$57.80

Item No.	Description	Max Fee (excl. GST)
66642	A test described in item 66641 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$57.80
66644	C-1 esterase inhibitor - quantitation	$40.10
66647	C-1 esterase inhibitor - functional assay	$89.30
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)	$48.10
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)	$48.10
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)	$40.30
66653	2 or more tests described in item 66650 (Item is subject to rule 6)	$88.30
66655	Prostate specific antigen quantitation For any particular patient, applicable not more than once in 23 months	$40.00
66656	Prostate specific antigen (PSA) quantitation in the monitoring of previously diagnosed prostatic disease (including prostate cancer, prostatitis or a premalignant condition such as atypical small acinar proliferation)	$40.00
66659	Prostate specific antigen (PSA), quantitation of 2 or more fractions of PSA and any derived index, including, if performed, a test described in item 66656, in the follow up of a PSA result under item 66654 or 66655 that lies at: (a) more than 2.0 ug/L but less than or equal to 5.5 ug/L for patients with a family history of prostate cancer; or (b) more than 3.0 ug/L but less than or equal to 5.5 ug/L for patients who are at least 50 years of age but under 70 years of age; or (c) more than 5.5 ug/L but less than or equal to 10.0 ug/L for patients who are at least 70 years of age For any particular patient, applicable not more than once in 11 months	$75.30
66660	Prostate specific antigen (PSA), quantitation of 2 or more fractions of PSA and any derived index, in the monitoring of previously diagnosed prostatic disease, including, if performed, a test described in item 66656, if the current PSA level lies at: (a) more than 2.0 ug/L but less than or equal to 5.5 ug/L for patients with a family history of prostate cancer; or (b) more than 3.0 ug/L but less than or equal to 5.5 ug/L for patients who are at least 50 years of age but under 70 years of age; or (c) more than 5.5 ug/L but less than or equal to 10.0 ug/L for patients who are at least 70 years of age For any particular patient, applicable not more than 4 times in 11 months	$74.40
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	$158.20
66663	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$158.20
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	$60.80
66666	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$60.60
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test	$60.60
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test	$73.00
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	$79.60
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old	$22.40
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests	$149.90
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests	$147.40
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	$100.20
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)	$60.60
66696	A test described in item 66695, if rendered by a receiving APP - where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18)	$60.40
66697	Tests described in item 66695, other than that described in 66696, if rendered by a receiving APP - each test to a maximum of 4 tests (Item is subject to rule 6 and 18)	$26.60
66698	2 tests described in item 66695 (Item is subject to rule 6)	$86.40
66701	3 tests described in item 66695 (Item is subject to rule 6)	$112.80

Item No.	Description	Max Fee (excl. GST)
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)	$138.70
66707	5 or more tests described in item 66695 (Item is subject to rule 6)	$165.00
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)	$61.10
66712	Two tests described in item 66711 (Item is subject to rule 6)	$87.60
66714	A test described in item 66711, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18)	$60.60
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)	$31.50
66716	TSH quantitation	$49.70
66719	Thyroid function tests (comprising the service described in item 66716 and either or both of a test for free thyroxine and a test for free T3) for a patient, if: (a) the patient has a level of TSH that is outside the normal reference range for the particular method of assay used to determine the level; or (b) the request from the requesting medical practitioner indicates that the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; or (c) the request from the requesting medical practitioner indicates that the medical practitioner suspects the patient has a pituitary dysfunction; or (d) the request from the requesting medical practitioner indicates that the patient is on drugs that interfere with thyroid hormone metabolism or function	$68.80
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)	$75.00
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)	$75.00
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)	$26.00
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)	$100.90
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)	$127.00
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)	$152.80
66734	TSH quantitation described in item 66716 and 5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form) (Item is subject to rule 6)	$179.00
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751	$40.80
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	$66.30
66750	Quantitation, in pregnancy, of any 2 of the following to detect foetal abnormality - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE3), alpha-fetoprotein (AFP) - including (if performed) a service described in item 73527 or 73529 - Applicable not more than once in a pregnancy	$80.10
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25)	$111.20
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	$50.00
66755	2 or more tests described in item 66752	$77.00

Item No.	Description	Max Fee (excl. GST)
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.	$194.50
66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type.	$194.50
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests	$50.00
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick)	$26.00
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	$17.70
66767	2 examinations described in item 66764 performed on separately collected and identified specimens	$36.10
66770	3 examinations described in item 66764 performed on separately collected and identified specimens	$53.00
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)	$48.80
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	$48.80
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	$79.20
66780	A test described in item 66779 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$79.20
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests	$26.50
66783	A test described in item 66782 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$26.00
66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test (Item is subject to rule 6)	$79.20
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests (Item is subject to rule 6)	$130.30
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)	$79.20
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)	$51.40
66791	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests	$147.40
66792	A test described in item 66791 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$147.40
66800	Quantitation in blood, urine or other body fluid by any method (except reagent tablet or reagent strip) of any of the following being used therapeutically by the patient from whom the specimen was taken: amikacin, carbamazepine, digoxin, disopyramide, ethanol, ethosuximide, gentamicin, lithium, lignocaine, netilmicin, paracetamol, phenobarbitone, primidone, phenytoin, procainamide, quinidine, salicylate, theophylline, tobramycin, valproate or vancomycin - 1 test (Item to be subject to rule 6)	$37.20
66803	2 tests described in item 66800 (Item is subject to rule 6)	$62.60
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)	$36.60
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)	$24.40
66806	3 tests described in item 66800 (Item is subject to rule 6)	$85.30
66812	Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$70.50
66815	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$117.80

Item No.	Description	Max Fee (excl. GST)
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)	$70.50
66817	A test described in item 66812, other than that described in 66816, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18)	$50.10
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)	$60.60
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)	$60.60
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)	$44.20
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)	$103.60
66825	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25)	$60.60
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)	$60.60
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)	$44.20
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)	$103.60
66829	Quantitation of BNP or NT proBNP for the exclusion of a diagnosis of heart failure in a patient presenting in a non hospital setting to assist in decision making regarding the clinical necessity of an echocardiogram, where heart failure is suspected based on signs and symptoms but diagnosis is uncertain Applicable once in any 12 month period	$87.80
66830	Quantitation of BNP or NT-proBNP for the diagnosis of heart failure in patients presenting with dyspnoea to a hospital Emergency Department (Item is subject to rule 25)	$119.20
66831	Quantitation of copper or iron in liver tissue biopsy	$62.20
66832	A test described in item 66831 if rendered by a receiving app (item is subject to rule 18a and 22)	$61.30
66833	25-hydroxyvitamin D, quantification in serum, for the investigation of a patient who: (a) has signs or symptoms of osteoporosis or osteomalacia; or (b) has increased alkaline phosphatase and otherwise normal liver function tests; or (c) has hyperparathyroidism, hypo- or hypercalcaemia, or hypophosphataemia; or (d) is suffering from malabsorption (for example, because the patient has cystic fibrosis, short bowel syndrome, inflammatory bowel disease or untreated coeliac disease, or has had bariatric surgery); or (e) has deeply pigmented skin, or chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons; or (f) is taking medication known to decrease 25OH-D levels (for example, anticonvulsants); or (g) has chronic renal failure or is a renal transplant recipient; or (h) is less than 16 years of age and has signs or symptoms of rickets; or (i) is an infant whose mother has established vitamin D deficiency; or (j) is a exclusively breastfed baby and has at least one other risk factor mentioned in a paragraph in this item; or (k) has a sibling who is less than 16 years of age and has vitamin D deficiency	$59.00
66834	A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18)	$59.00
66835	1, 25-dihydroxyvitamin D - quantification in serum, if the request for the test is made by, or on advice of, the specialist or consultant physician managing the treatment of the patient	$76.50
66836	1, 25-dihydroxyvitamin D-quantification in serum, if: (a) the patient has hypercalcaemia; and (b) the request for the test is made by a general practitioner managing the treatment of the patient	$76.50
66837	A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18)	$76.50
66838	Quantification of either or both of total vitamin B12 and holotranscobalamin Applicable not more than once in 11 months	$46.20
66839	Quantification of methylmalonic acid or homocysteine, rendered in the same patient episode as a service to which item 66838 applies if the result of that service is inconclusive or abnormal Applicable not more than once in 11 months	$84.00
66840	Serum folate test and, if required, red cell folate test for a patient at risk of folate deficiency, including patients with malabsorption conditions, macrocytic anaemia or coeliac disease	$46.20
66841	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk. (Item is subject to rule 25)	$32.70

Item No.	Description	Max Fee (excl. GST)
66842	Quantification of one or more of total vitamin B12, holotranscobalamin, methylmalonic acid or homocysteine for a patient: (a) who: (i) is still experiencing symptoms of vitamin B12 deficiency 3 to 6 months after a service described in item 66838 or 66839 was rendered for the patient; or (ii) obtained inconclusive results from a service described in item 66839; or (b) to whom one or more of the following applies: (i) the patient has a diet low in vitamin B12; (ii) the patient has a family history of vitamin B12 deficiency or an autoimmune condition; (iii) the patient has previously had abdominal or pelvic radiotherapy; (iv) the patient has previously had surgery involving the gastrointestinal tract; (v) the patient uses, or has a recent history of using, recreational nitrous oxide; (vi) the patient requires monitoring of vitamin B12 treatment; (vii) the patient uses vitamin B12-antagonistic medicines; (viii) the patient has one or more clinical conditions with a recognised risk of vitamin B12 deficiency	$35.40
66900	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, including the measurement of exhaled 13CO2 or 14CO2 (except if item 12533 applies) for either:- (a) the confirmation of Helicobacter pylori colonisation OR (b) the monitoring of the success of eradication of Helicobacter pylori.	$153.60
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	$24.90
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	$43.50
69306	Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens	$66.60
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Schedule; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens	$96.70
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	$66.60
69316	Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26)	$56.60
69317	1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26)	$70.90
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	$66.60
69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26)	$87.00
69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites	$97.10
69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service described in item 69300	$86.40
69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18)	$85.00
69327	Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	$169.30
69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18)	$168.00
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	$256.70
69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18)	$253.20

Item No.	Description	Max Fee (excl. GST)
69333	Urine examination (including serial examinations), if: (a) the patient has symptoms of urinary tract infection or kidney disease, or is a clinically indicated asymptomatic patient who is: (i) pregnant; or (ii) less than 16 years of age; or (iii) a renal transplant recipient; or (iv) suffering from recurrent urinary tract infections; or (v) being investigated or monitored for kidney disease; or (vi) undergoing urinary tract instrumentation, a urological procedure or transurethral resection of the prostate; and (b) the examination is performed by any means other than simple culture by dip slide, including: (i) cell count; and (ii) culture; and (iii) colony count; and (iv) (if performed) stained preparations; and (v) (if performed) identification of cultured pathogens; and (vi) (if performed) antibiotic susceptibility testing; and (vii) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts	$40.80
69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service described in item 69300 - 1 of this item in any 7 day period	$67.70
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	$37.90
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	$104.70
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	$64.60
69357	2 sets of cultures described in item 69354	$128.60
69360	3 sets of cultures described in item 69354	$192.50
69363	Detection of clostridium difficile or clostridium difficile toxin (except if a service described in item 69345 has been performed) - one or more tests	$56.60
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	$356.30
69379	A test described in item 69378 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$356.30
69380	Genotypic testing for HIV antiretroviral resistance in a patient with confirmed HIV infection if the patient's viral load is greater than 1,000 copies per ml at any of the following times: (a) at presentation; or (b) before antiretroviral therapy: or (c) when treatment with combination antiretroviral agents fails; maximum of 2 tests in a 12 month period	$1,509.90
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	$356.30
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	$356.30
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)	$356.30
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)	$31.10
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$57.50
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$85.40
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$118.50
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 the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$135.40
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)	$31.10
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)	$26.40

Item No.	Description	Max Fee (excl. GST)
69405	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$31.10
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	$57.50
69411	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$83.90
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	$110.10
69415	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$135.40
69421	Detection of respiratory pathogen nucleic acid from a nasal swab, throat swab, nasopharyngeal aspirate and/or lower respiratory tract sample Testing of 4 pathogens	$135.50
69422	Detection of respiratory pathogen nucleic acid from a nasal swab, throat swab, nasopharyngeal aspirate and/or lower respiratory tract sample, including a service described in item 69421 Testing of 5 or more pathogens	$148.00
69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69499) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 25)	$182.30
69451	A test described in item 69445 if rendered by a receiving APP - 1 test. (Item is subject to rule 18 and 25)	$182.30
69471	Test of cell mediated immune response in blood for the detection of latent tuberculosis by interferon gamma release assay (IGRA) in the following people: (a) a person who has been exposed to a confirmed case of active tuberculosis; (b) a person who is infected with human immunodeficiency virus; (c) a person who is to commence, or has commenced, tumour necrosis factor (TNF) inhibitor therapy; (d) a person who is to commence, or has commenced, renal dialysis; (e) a person with silicosis; (f) a person who is, or is about to become, immunosuppressed because of a disease, or a medical treatment, not mentioned in paragraphs (a) to (e)	$70.60
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test	$31.10
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests	$56.60
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)	$31.10
69478	2 tests described in 69475 (item subject to rule 11)	$57.80
69481	Investigation of infectious causes of acute or chronic hepatitis - 3 tests for hepatitis antibodies or antigens, (item subject to rule 11)	$80.10
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)	$300.90
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)	$300.90
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)	$34.50
69488	Quantitation of HCV RNA load in plasma or serum in: (a) the pre-treatment evaluation, of a patient with chronic HCV hepatitis, for antiviral therapy; or (b) the assessment of efficacy of antiviral therapy for such a patient (including a service in item 69499 or 69445) (Item is subject to rule 18 and 25)	$356.30
69489	A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25)	$356.30
69491	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis. To a maximum of 1 of this item in a 12 month period	$405.10
69492	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)	$405.10

Item No.	Description	Max Fee (excl. GST)
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)	$56.60
69495	2 tests described in 69494 (Item is subject to rule 6 and 26)	$70.90
69496	3 or more tests described in 69494 (Item is subject to rule 6 and 26)	$87.20
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)	$56.60
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)	$14.40
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)	$182.30
69500	A test described in item 69499 if rendered by a receiving APP - 1 test (Item is subject to rule 18,19 and 25)	$182.30
69505	Sequencing and analysis of the genome of mycobacterium tuberculosis complex from an isolate or nucleic acid extract: (a) to speciate the organism: (i) at the time of a patient s initial diagnosis and commencement of initial empiric therapy; or (ii) following recurrence of a patient s symptoms or a patients failure to respond to treatment within the expected timeframe; and (b) for the purpose of: (i) genome wide determination of the antimicrobial resistance markers (resistome) of the isolate; and (ii) individualising the patient s treatment Applicable once at initial diagnosis and once per episode of disease recurrence	$285.10
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	$66.20
71058	Examination as described in item 71057 of 2 or more specimen types	$102.00
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)	$72.60
71060	Examination as described in item 71059 of 2 or more specimen types	$88.60
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	$88.60
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests	$41.20
71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test	$28.80
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test	$28.80
71069	2 tests described in items 71066, 71068, 71072 or 71074	$45.10
71071	3 or more tests described in items 71066, 71068, 71072 or 71074	$61.60
71072	Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test	$28.80
71073	Quantitation of all 4 immunoglobulin G subclasses	$210.30
71074	Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test	$28.80
71075	Quantitation of immunoglobulin e (total), 1 test. (Item is subject to rule 25)	$45.60
71076	A test described in item 71073 if rendered by a receiving APP - 1 test (Item is subject to rule 18)	$209.90
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)	$53.50
71079	Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25)	$53.10
71081	Quantitation of total haemolytic complement	$82.10
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test	$40.10
71085	2 tests described in item 71083	$57.60
71087	3 or more tests described in item 71083	$77.20
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)	$57.80

Item No.	Description	Max Fee (excl. GST)
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)	$57.60
71091	2 tests described in item 71089 (Item is subject to rule 6)	$104.90
71092	Tests described in item 71089, other than that described in 71090, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18)	$48.00
71093	3 or more tests described in item 71089 (Item is subject to rule 6)	$151.80
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	$80.10
71096	A test described in item 71095 if rendered by a receiving APP. (Item is subject to rule 18)	$80.10
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required	$48.50
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method	$52.60
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids	$34.60
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service)	$103.30
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required	$22.40
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody	$34.60
71121	Detection of 2 antibodies specified in item 71119	$41.20
71123	Detection of 3 antibodies specified in item 71119	$48.10
71125	Detection of 4 or more antibodies specified in item 71119	$55.00
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	$349.90
71129	2 tests described in item 71127	$432.10
71131	3 or more tests described in item 71127	$514.40
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	$21.00
71134	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)	$205.80
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	$412.40
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	$70.30
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	$206.40
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	$391.60
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	$515.60
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	$883.60
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	$205.80
71147	HLA-B27 typing (Item is subject to rule 27)	$80.10
71148	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27)	$80.10
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	$214.60

Item No.	Description	Max Fee (excl. GST)
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	$235.80
71153	Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis - antineutrophil cytoplasmic antibody immunofluorescence (ANCA test), antineutrophil proteinase 3 antibody (PR-3 ANCA test), antimyeloperoxidase antibody (MPO ANCA test) or antiglomerular basement membrane antibody (GBM test) - detection of 1 antibody (Item is subject to rule 6 and 23)	$68.40
71154	A test described in item 71153, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test. (Item is subject to rule 6, 18 and 23)	$68.40
71155	Detection of 2 antibodies described in item 71153 (Item is subject to rule 6 and 23)	$94.20
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)	$25.60
71157	Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 23)	$119.80
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23)	$145.20
71163	Detection of one of the following antibodies (of 1 or more class or isotype) in the assessment or diagnosis of coeliac disease or other gluten hypersensitivity syndromes and including a service described in item 71066 (if performed): (a) Antibodies to gliadin; or (b) Antibodies to endomysium; or (c) Antibodies to tissue transglutaminase; - 1 test	$50.10
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed)	$79.10
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)	$68.40
71166	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6)	$93.90
71167	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6)	$119.50
71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6)	$144.70
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)	$68.40
71170	Tests described in item 71165, other than that described in 71169, if rendered by a receiving APP - each test to a maximum of 3 tests (Item is subject to rule 6 and 18)	$25.60
71175	A test, requested by a specialist or consultant physician, to diagnose neuromyelitis optica spectrum disorder (NMOSD) or myelin oligodendrocyte glycoprotein antibody related demyelination (MARD), by the detection of one or more antibodies, for a patient: suspected of having NMOSD or MARD; and with any of the following: recurrent, bilateral or severe optic neuritis; recurrent longitudinal extensive transverse myelitis (LETM); area postrema syndrome (unexplained hiccups, nausea or vomiting); acute brainstem syndrome; symptomatic narcolepsy or acute diencephalic clinical syndrome with typical NMOSD magnetic resonance imaging lesions; symptomatic cerebral syndrome with typical NMOSD magnetic resonance imaging lesions; monophasic neuromyelitis optica (no recurrence, and simultaneous or closely related optic neuritis and LETM within 30 days of each other); acute disseminated encephalomyelitis; aseptic meningitis and encephalomyelitis; poor recovery from multiple sclerosis relapses Applicable not more than 4 times in 12 months	$106.20
71180	Antibody to cardiolipin or beta-2 glycoprotein I - detection, including quantitation if required; one antibody specificity (IgG or IgM)	$68.40
71183	Detection of two antibodies described in item 71180	$93.90
71186	Detection of three or more antibodies described in item 71180	$119.50
71189	Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified.	$31.40
71192	2 items described in item 71189.	$56.20
71195	3 or more items described in item 71189.	$79.30
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.	$80.10
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.	$100.10
71203	Determination of HLAB5701 status by flow cytometry or cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed.	$80.10

Item No.	Description	Max Fee (excl. GST)
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)	$145.10
72814	Immunohistochemical examination by immunoperoxidase or other labelled antibody techniques using the programmed cell death ligand 1 (PD L1) antibody of tumour material from a patient diagnosed with: (a) non small cell lung cancer; or (b) recurrent or metastatic squamous cell carcinoma of the oral cavity, pharynx or larynx; or (c) locally recurrent unresectable or metastatic triple-negative breast cancer.	$147.70
72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13)	$170.90
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13)	$191.70
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (Item is subject to rule 13)	$217.70
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)	$196.60
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13)	$297.60
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)	$367.20
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)	$393.80
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)	$422.50
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)	$451.20
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)	$560.30
72836	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13)	$832.20
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)	$930.40
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	$62.10
72846	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 72848 (Item is subject to rule 13)	$118.40
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)	$180.40
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)	$147.80
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)	$206.00
72850	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies (Item is subject to rule 13)	$234.70

Item No.	Description	Max Fee (excl. GST)
72851	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13)	$444.00
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13)	$610.20
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)	$390.00
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)	$490.40
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)	$580.30
72858	A second opinion, provided in a written report, where the opinion and report together require no more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management.	$378.20
72859	A second opinion, provided in a written report, where the opinion and report together require more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management.	$777.50
72860	Retrieval and review of one or more archived formalin fixed paraffin embedded blocks to determine the appropriate samples for the purpose of conducting genetic testing, other than: (a) a service associated with a service to which item 72858 or 72859 applies; or (b) a service associated with, and rendered in the same patient episode as, a service to which an item in Group P5, P6, P10 or P11 applies Applicable not more than once in a patient episode	$168.50
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	$45.30
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73076); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests	$99.10
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells	$184.90
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 1 identified site	$139.50
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	$344.10
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061 (Item is subject to rule 13)	$87.10
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 to 6 antibodies (Item is subject to rule 13)	$113.90
73061	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13)	$103.20
73062	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 2 or more separately identified sites.	$176.10
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	$196.60
73064	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 7 to 10 antibodies (Item is subject to rule 13)	$141.90
73065	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies (Item is subject to rule 13)	$170.10

Item No.	Description	Max Fee (excl. GST)
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	$434.20
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	$253.10
73070	73070 A test, including partial genotyping, for oncogenic human papillomavirus that may be associated with cervical pre cancer or cancer: (a) performed on a liquid based cervical specimen; and (b) for an asymptomatic patient who is at least 24 years and 9 months of age For any particular patient, once only in a 57 month period	$71.00
73071	A test, including partial genotyping, for oncogenic human papillomavirus that may be associated with cervical pre cancer or cancer, if performed: (a) on a self collected vaginal specimen; and (b) for an asymptomatic patient who is at least 24 years and 9 months of age For any particular patient, applicable once in 57 months	$71.00
73072	A test, including partial genotyping, for oncogenic human papillomavirus: (a) for the investigation of a patient in a specific population that appears to have a higher risk of cervical pre cancer or cancer; or (b) for the follow up management of a patient with a previously detected oncogenic human papillomavirus infection or cervical pre cancer or cancer; or (c) for the investigation of a patient with symptoms suggestive of cervical cancer; or (d) for the follow up management of a patient after treatment of high grade squamous intraepithelial lesions or adenocarcinoma in situ of the cervix; or (e) for the follow up management of a patient with glandular abnormalities; or (f) for the follow up management of a patient exposed to diethylstilboestrol in utero; or (g) for a patient previously treated for a genital tract malignancy when performed as a co-test for both human papillomavirus (HPV) and liquid-based cytology (LBC).	$71.00
73074	A test, including partial genotyping, for oncogenic human papillomavirus, for the investigation of a patient following a total hysterectomy.	$71.00
73075	A test, including partial genotyping, for oncogenic human papillomavirus, if: (a) the test is a repeat of a test to which item 73070, 73071, 73072, 73074 or this item applies; and (b) the specimen collected for the previous test is unsatisfactory	$71.00
73076	Cytology of a liquid based cervical or vaginal vault specimen, where the stained cells are examined microscopically or by automated image analysis by or on behalf of a pathologist, if: (a) the cytology is associated with the detection of oncogenic human papillomavirus infection by: (i) a test to which item 73070, 73071, 73074 or 73075 applies; or (ii) a test to which item 73072 applies for a patient mentioned in paragraph (a) or (b) of that item; or (b) the cytology is associated with a test to which item 73072 applies for a patient mentioned in paragraph (c), (d), (e) or (f) of that item; or (c) the cytology is associated with a test to which item 73074 applies; or (d) the test is a repeat of a test to which this item applies, if the specimen collected for the previous test is unsatisfactory; or (e) the cytology is for the follow up management of a patient treated for endometrial adenocarcinoma	$93.20
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	$798.60
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	$710.10
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.	$780.50
73291	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in (a) diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities, in whom cytogenetic studies (item 73287 or 73289) are either normal or have not been performed; or (b) studies of a relative for an abnormality previously identified in such an affected person. - 1 or more tests.	$456.80
73292	Analysis of chromosomes by genome-wide micro-array including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities (including a service in items 73287, 73289 or 73291, if performed) - 1 or more tests.	$1,166.70
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.	$456.80
73294	Analysis of the PMP22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as: (a) diagnostic studies of an affected person; or (b) studies of a relative for an abnormality previously identified in an affected person - 1 or more tests.	$456.80
73295	Detection of germline BRCA1 or BRCA2 pathogenic or likely pathogenic gene variants, requested by a specialist or consultant physician, to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme (PBS), in a patient with: (a) advanced (FIGO III IV) high grade serous or high grade epithelial ovarian, fallopian tube or primary peritoneal cancer for whom testing of tumour tissue is not feasible; or (b) breast cancer. Applicable once per lifetime	$2,469.00

Item No.	Description	Max Fee (excl. GST)
73296	Characterisation of germline gene variants, including copy number variation where appropriate, requested by a specialist or consultant physician: (a) in genes associated with breast, ovarian, fallopian tube or primary peritoneal cancer, which must include at least: (i) BRCA1 and BRCA 2 genes; and (ii) one or more other relevant genes; and (b) in a patient: (i) with breast, ovarian, fallopian tube or primary peritoneal cancer; and (ii) for whom clinical and family history criteria place the patient at greater than 10% risk of having a pathogenic or likely pathogenic gene associated with breast, ovarian, fallopian tube or primary peritoneal cancer Once per cancer diagnosis	$2,430.30
73297	Characterisation of germline gene variants, including copy number variation where appropriate, requested by a specialist or consultant physician: (a) in genes associated with breast, ovarian, fallopian tube or primary peritoneal cancer, which may include the following genes: (i) BRCA1 or BRCA2; (ii) one or more other relevant genes; and (b) in a patient: (i) who has a biological relative who has had a pathogenic or likely pathogenic gene variant identified in one or more of the genes mentioned in paragraph (a); and (ii) who has not previously received a service to which item 73295, 73296 or 73302 applies Once per variant	$810.00
73298	Characterisation of germline gene variants in the following genes: (a) COL4A3; and (b) COL4A4; and (c) COL4A5; in a patient for whom clinical and relevant family history criteria have been assessed by a specialist or consultant physician, who requests the service to be strongly suggestive of Alport syndrome.	$2,376.70
73299	Characterisation of germline gene variants: (a) in the following genes: (i) COL4A3; and (ii) COL4A4; and (iii) COL4A5; (b) in a patient who: (i) is a first degree biological relative of a patient who has had a pathogenic mutation identified in one or more of the genes mentioned in subparagraphs (a) (i), (ii) and (iii); and (ii) has not previously received a service which item 73298 applies; requested by a specialist or consultant physician.	$792.30
73300	Detection of mutation of the FMR1 gene where: (a) the patient exhibits intellectual disability, ataxia, neurodegeneration, or premature ovarian failure consistent with an FMRI mutation; or (b) the patient has a relative with a FMR1 mutation 1 or more tests	$200.10
73305	Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive	$400.90
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	$72.30
73309	A test described in item 73308, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$72.30
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	$72.30
73312	A test described in item 73311, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$72.30
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;	$456.90
73315	A test described in item 73314, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)	$456.90
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)	$72.30
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)	$72.30
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)	$80.10
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)	$80.10
73323	Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed.	$80.10
73324	A test described in item 73323 if rendered by a receiving APP 1 or more tests (Item is subject to Rule 18)	$81.10
73325	Determination of JAK2 V617F variant allele frequency in the diagnostic work up by, or on behalf of, a specialist or consultant physician, for a patient with clinical and laboratory evidence of a myeloproliferative neoplasm	$189.40
73326	Characterisation of the gene rearrangement FIP1L1-PDGFRA in the diagnostic work-up and management of a patient with laboratory evidence of: (a) mast cell disease; or (b) idiopathic hypereosinophilic syndrome; or (c) chronic eosinophilic leukaemia;. 1 or more tests	$452.90
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	$101.90

Item No.	Description	Max Fee (excl. GST)
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.	$618.10
73333	Detection of germline mutations of the von Hippel Lindau (VHL) gene: (a) in a patient who has a clinical diagnosis of VHL syndrome and: (i) a family history of VHL syndrome and one of the following: (A) haemangioblastoma (retinal or central nervous system); (B) phaeochromocytoma; (C) renal cell carcinoma; or (ii) 2 or more haemangioblastomas; or (iii) one haemangioblastoma and a tumour or a cyst of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; or (E) a broad ligament (other than epididymal and single renal cysts, which are common in the general population); or (b) in a patient presenting with one or more of the following clinical features suggestive of VHL syndrome: (i) haemangiblastomas of the brain, spinal cord, or retina; (ii) phaeochromocytoma; (iii) functional extra adrenal paraganglioma	$1,267.20
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	$718.30
73335	Detection of somatic mutations of the von Hippel-Lindau (VHL) gene in a patient with: (a) 2 or more tumours comprising: (i) 2 or more haemangioblastomas, or (ii) one haemangioblastoma and a tumour of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; and (b) no germline mutations of the VHL gene identified by genetic testing	$992.70
73336	A test of tumour tissue from a patient with stage III or stage IV metastatic cutaneous melanoma, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to BRAF V600 mutation status for access to dabrafenib, vemurafenib or encorafenib under the Pharmaceutical Benefits Scheme are fulfilled.	$465.90
73337	A test of tumour tissue from a patient with a new diagnosis of non-small cell lung cancer, requested by, or on behalf of, a specialist or consultant physician, if the test is: (a) for epidermal growth factor receptor (EGFR) status to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; and (b) not associated with a service to which item 73437 or 73438 applies	$801.60
73338	A test of tumour tissue from a patient with metastatic colorectal cancer (stage IV), requested by a specialist or consultant physician, to determine if: (a) requirements relating to rat sarcoma oncogene (RAS) gene variant status for access to cetuximab or panitumumab under the Pharmaceutical Benefits Scheme are fulfilled, if: the test is conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4; or a clinically-relevant RAS variant is detected; and, in cases where no RAS variant is detected (b) the requirements relating to BRAF V600 gene variant status for access to encorafenib under the Pharmaceutical Benefits Scheme are fulfilled.	$562.80
73339	Detection of germline mutations in the RET gene in patients with a suspected clinical diagnosis of multiple endocrine neoplasia type 2 (MEN2) requested by a specialist or consultant physician who manages the treatment of the patient. One test. (Item is subject to rule 25)	$782.80
73340	Detection of a known mutation in the RET gene in an asymptomatic relative of a patient with a documented pathogenic germline RET mutation requested by a specialist or consultant physician who manages the treatment of the patient. One test. (Item is subject to rule 25)	$391.40
73341	Fluorescence in situ hybridisation (FISH) test of tumour tissue from a patient with a new diagnosis of non-small cell lung cancer, requested by a specialist or consultant physician, if the test is: (a) for ALK gene rearrangement status to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; and (b) not associated with a service to which item 73437 or 73439 applies	$840.40
73342	An in situ hybridisation (ISH) test of tumour tissue from a patient with metastatic adenocarcinoma of the stomach or gastro-oesophageal junction, with documented evidence of human epidermal growth factor receptor 2 (HER2) overexpression by immunohistochemical (IHC) examination giving a staining intensity score of 2+ or 3+ on the same tumour tissue sample, requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to HER2 gene amplification for access to trastuzumab under the pharmaceutical benefits scheme are fulfilled.	$662.40
73343	Detection of 17p chromosomal deletions, in a patient with chronic lymphocytic leukaemia or small lymphocytic lymphoma, on a peripheral blood, bone marrow or lymph node sample, requested by a specialist or consultant physician For any particular patient: (a) at initial diagnosis; or (b) at disease relapse; or (c) on disease progression; but only where initiation of, or change in, therapy is anticipated	$514.40
73344	Fluorescence in situ hybridization (FISH) test of tumour tissue from a patient with a new diagnosis of non-small cell lung cancer, requested by a specialist or consultant physician, if the test is: (a) for ROS1 gene arrangement status to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; and (b) not associated with a service to which item 73437 or 73439 applies	$792.30
73345	Testing of a patient for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of investigating, making or excluding a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73347, 73348, or 73349 applies. The patient must have clinical or laboratory findings suggesting there is a high probability suggestive of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder.	$1,012.70

Item No.	Description	Max Fee (excl. GST)
73346	Testing of a pregnant patient whose carrier status for pathogenic cystic fibrosis transmembrane conductance regulator variants, as well as their reproductive partner carrier status is unknown, for the purpose of determining whether pathogenic cystic fibrosis transmembrane conductance regulator variants are present in the fetus, in order to make or exclude a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder in the fetus when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73350 applies. The fetus must have ultrasonic findings of echogenic gut, with unknown familial cystic fibrosis transmembrane conductance regulator variants.	$1,012.70
73347	Testing of a prospective parent for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining the risk of their fetus having pathogenic cystic fibrosis transmembrane conductance regulator variants. This is indicated when the fetus has ultrasonic evidence of echogenic gut when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73348, or 73349 applies.	$1,012.70
73348	Testing of a patient with a laboratory-established family history of pathogenic cystic fibrosis transmembrane conductance regulator variants, for the purpose of determining whether the patient is an asymptomatic genetic carrier of the pathogenic cystic fibrosis transmembrane conductance regulator variants that have been laboratory established in the family history, not being a service associated with a service to which item 73345, 73347, or 73349 applies. The patient must have a positive family history, confirmed by laboratory findings of pathogenic cystic fibrosis transmembrane conductance regulator variants, with a personal risk of being a heterozygous genetic carrier of at least 6%. (This includes family relatedness of: parents, children, full-siblings, half-siblings, grand-parents, grandchildren, aunts, uncles, first cousins, and first cousins once-removed, but excludes relatedness of second cousins or more distant relationships).	$506.20
73349	Testing of a patient for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining the reproductive risk of the patient with their reproductive partner because their reproductive partner is already known to have pathogenic cystic fibrosis transmembrane conductance regulator variants requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73347, or 73348 applies.	$1,012.70
73350	Testing of a pregnant patient, where one or both prospective parents are known to be a genetic carrier of pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining whether pathogenic cystic fibrosis transmembrane conductance regulator variants are present in the fetus in order to make or exclude a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder in the fetus, when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73346 applies. The fetus must be at 25% or more risk of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder because of known familial cystic fibrosis transmembrane conductance regulator variants.	$506.20
73351	A test of tumour tissue that is derived from a new sample from a patient with locally advanced (Stage IIIb) or metastatic (Stage IV) non-small cell lung cancer (NSCLC), who has progressed on or after treatment with an epidermal growth factor receptor tyrosine kinase inhibitor (EGFR TKI). The test is to be requested by a specialist or consultant physician, to determine if the requirements relating to EGFR T790M gene status for access to osimertinib under the Pharmaceutical Benefits Scheme are fulfilled.	$787.10
73422	Characterisation of a gene variant or gene variants using a gene panel, in a patient presenting with clinical signs and symptoms suggestive of a genetic neuromuscular disorder (other than signs and symptoms associated with variants that are not detectable by massively parallel sequencing), if the service is requested: (a) by a specialist or consultant physician; and (b) after exclusion of non genetic causes Applicable once per lifetime	$2,448.50
73423	Detection of a single identified gene variant, in a biological relative of a person with a germline gene variant for a neuromuscular disorder identified by a service described in item 73422, 73425 or 73426, if the service is requested by a specialist or consultant physician Applicable once per variant	$1,020.30
73424	Prenatal detection of an actionable pathogenic familial gene variant or gene variants (including maternal cell contamination assessment), requested by a specialist or consultant physician, for a genetic neuromuscular disorder previously identified in an index person in the patient s family as a result of a service described in item 73422, 73434 or 73435 Applicable once per pregnancy	$3,264.70
73425	Prenatal detection of unknown gene variants (including maternal cell contamination assessment) using a gene panel, if: (a) the service is requested: (i) by a specialist or consultant physician, for a suspected genetic neuromuscular disorder; and (ii) after exclusion of non genetic causes; and (b) the service is performed using a sample from the fetus; and (c) the service is not performed in conjunction with a service to which item 73426 applies Applicable once per pregnancy	$3,672.90
73426	Prenatal detection of unknown gene variants (including maternal cell contamination assessment) using a gene panel, if: (a) the service is requested: (i) by a specialist or consultant physician; and (ii) for a suspected genetic neuromuscular disorder; and (iii) after exclusion of non genetic causes; and (b) the request states that singleton testing is inappropriate; and (c) the service is performed using a sample from the fetus and a sample from each of the fetus s biological parents; and (d) the service is not performed in conjunction with a service to which item 73425 applies Applicable once per pregnancy	$4,897.20
73427	Single gene testing for the characterisation of a germline gene variant or germline gene variants: (a) if requested by a specialist or consultant physician; and (b) within the same gene in which the patient s reproductive partner has a documented pathogenic germline recessive gene variant for a neuromuscular disorder identified by a service described in: (i) item 73422, 73425 or 73426; or (ii) item 73434, if the patient has been provided a service described in item 73434 and that service has not identified a relevant variant Applicable once per gene	$2,448.50

Item No.	Description	Max Fee (excl. GST)
73429	Genetic testing (including characterisation of single nucleotide variants, structural variants, fusions and copy number alterations) in a gene panel, requested by a specialist or consultant physician, for a patient with clinical or laboratory evidence of a glioma, glioneuronal tumour or glioblastoma, to aid diagnosis and classification of the relevant tumour, including assessments of at least the following kinds: (a) IDH1, IDH2 variant testing; (b) 1p/19q co deletion assessment; (c) H3F3A variant status; (d) TERT promoter variant status; (e) EGFR amplification; (f) CDKN2A/B deletion; (g) BRAF variants Applicable to one test per diagnostic episode	$1,688.10
73434	Detection of pathogenic or likely pathogenic gene variants, requested by a specialist or consultant physician, for any of the following: (a) a patient with a suspected neuromuscular disorder, being a neuromuscular disorder with signs and symptoms associated with variants that are not detectable by massively parallel sequencing; (b) a relative of a patient with a pathogenic or likely pathogenic germline gene variant associated with a neuromuscular disorder (confirmed by laboratory findings); (c) the reproductive partner of a patient with a recessive pathogenic or likely pathogenic germline gene variant associated with a neuromuscular disorder (confirmed by laboratory findings) Applicable once per gene per lifetime	$745.20
73435	Detection of pathogenic or likely pathogenic DUX4 gene variants, requested by a specialist or consultant physician, for: (a) a patient with a suspected neuromuscular disorder; or (b) a relative of a patient with a pathogenic or likely pathogenic germline gene variant associated with a neuromuscular disorder (confirmed by laboratory findings) Applicable once per gene per lifetime	$1,901.10
73436	A test of tumour tissue from a patient with a new diagnosis of non-small cell lung cancer requested by, or on behalf of, a specialist or consultant physician, if the test is: (a) for MET proto-oncogene, receptor tyrosine kinase (MET) exon 14 skipping alterations (METex14sk) status to determine eligibility for access to a relevant treatment under the Pharmaceutical Benefits Scheme; and (b) not associated with a service to which item 73437 or 73438 applies	$810.80
GROUP P8—INFERTILITY AND PREGNANCY TESTS		
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test)	$19.60
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)	$91.30
73525	Sperm antibodies - sperm-penetrating ability - 1 or more tests	$57.40
73527	Human chorionic gonadotrophin (hcg) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests	$19.80
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	$56.60
GROUP P9—SIMPLE BASIC PATHOLOGY TESTS		
73801	Semen examination for presence of spermatozoa	$14.00
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test	$9.20
73803	2 tests described in item 73802	$12.60
73804	3 or more tests described in item 73802	$16.50
73805	Microscopy of urine, excluding dipstick testing.	$9.20
73806	Pregnancy test by 1 or more immunochemical methods	$20.60
73807	Microscopy for wet film other than urine, including any relevant stain	$14.00
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807	$19.90
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method	$4.70
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites	$15.90
73811	Mantoux test	$22.80
73812	Quantitation of glycated haemoglobin (HbA1c) performed in the management of established diabetes, if performed: (a) as a point of care test; and (b) by or on behalf of a medical practitioner who works in a general practice that is accredited to the Royal Australian College of General Practitioners Standards for point of-care testing under the National General Practice Accreditation Scheme; and (c) using a method certified by the National Glycohemoglobin Standardization Program (NGSP), if the instrumentation used has a total coefficient variation less than 3.0% at 48mmol/mol (6.5%) Applicable not more than 3 times per 12 months per patient	$25.00
73813	Detection performed by, or on behalf of, a medical practitioner of: (a) chlamydia trachomatis (CT) and neisseria gonorrhoeae (NG) via molecular point-of-care testing for the diagnosis of CT or NG infection; and (b) trichomonas vaginalis (TV) via molecular point-of-care testing for the diagnosis of TV infection	$176.50

Item No.	Description	Max Fee (excl. GST)
GROUP P10—PATIENT EPISODE INITIATION		
73899	Initiation of a patient episode that consists of a service described in item 72858 or 72859 in circumstances other than those mentioned in item 73900	$12.40
73900	Initiation of a patient episode that consists of a service described in item 72858 or 72859 if the service is rendered in a prescribed laboratory.	$4.70
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	$4.80
73922	Initiation of a patient episode that consists of a service described in item 73070, 73071, 73072, 73074, 73075 or 73076 (in circumstances other than those described in item 73923)	$16.50
73923	Initiation of a patient episode that consists of a service described in items 73070, 73071, 73072, 73074, 73075 or 73076 if: (a) the person is a private patient in a recognised hospital; or (b) the person receives the service from a prescribed laboratory	$4.80
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.	$29.50
73925	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 if the person is: (a) a private patient of a recognised hospital; or (b) a private patient of a hospital who receives the service or services from a prescribed laboratory.	$4.90
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.	$16.50
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.	$4.80
73928	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item 73920 or 73929 applies	$12.00
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	$4.80
73930	Initiation of a patient episode by collection of a specimen for a service for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital. Unless item 73931 applies	$15.90
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	$4.90
73932	Initiation of a patient episode by collection of a specimen for one or more services (in circumstances other than those described in item 73922, 73923, 73924, 73925, 73926, 73927 or 73933) if: (a) the specimen is collected from a person in the place where the person resides; and (b) the place where the person resides is not a care institution or a residential aged care facility; and (c) the specimen is collected by: (i) an approved pathology practitioner of an approved pathology authority; or (ii) an employee of an approved pathology authority.	$20.80
73933	Initiation of a patient episode by collection of a specimen for one or more services (in circumstances other than those described in item 73922, 73923, 73924, 73925, 73926 or 73927) if: (a) the specimen is collected from a person in the place where the person resides; and (b) the place where the person resides is not a care institution or a residential aged care facility; and (c) the specimen is collected by: (i) an approved pathology practitioner of a prescribed laboratory; or (ii) an employee of an approved pathology authority that operates a prescribed laboratory	$4.80
73934	Initiation of a patient episode by collection of a specimen for one or more services (in circumstances other than those described in item 73922, 73923, 73924, 73925, 73926, 73927 or 73935) if: (a) the specimen is collected from a person in a care institution or a residential aged care facility; and (b) the specimen is collected by: (i) an approved pathology practitioner of an approved pathology authority; or (ii) an employee of an approved pathology authority	$34.90
73935	Initiation of a patient episode by collection of a specimen for one or more services (in circumstances other than those described in item 73922, 73923, 73924, 73925, 73926 or 73927) if: (a) the specimen is collected from a person in a care institution or a residential aged care facility; and (b) the specimen is collected by: (i) an approved pathology practitioner of a prescribed laboratory; or (ii) an employee of an approved pathology authority that operates a prescribed laboratory	$4.80

Item No.	Description	Max Fee (excl. GST)
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.	$12.10
73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected from the person by the person and if: () the service is performed in a prescribed laboratory or () the person is a private patient in a recognised hospital	$4.80
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	$16.20
73939	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if: () the service is performed in a prescribed laboratory or () the person is a private patient in a recognised hospital	$4.80
GROUP P11—SPECIMEN REFERRED		
73940	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of another approved pathology authority	$20.80
GROUP A35—SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES		
90001	For the first patient attended during one attendance by a general practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90020, 90035, 90043, 90051 or 90054 applies is the amount listed in the item plus $114.30.	$165.50
90002	For the first patient attended during one attendance by a medical practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90092, 90093, 90095, 90096, 90098, 90183, 90188, 90202, 90212 or 90215 applies is the amount listed in the item plus $83.10.	$120.20
90020	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (other than accommodation in a self contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on one or more patients at one residential aged care facility on one occasion - each patient.	$123.60
90035	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient (subject to Clause 2.30.1)	$171.40
90043	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$254.20
90051	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$353.80
90054	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;for one or more health-related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient (subject to Clause 2.30.1)	$522.90

Item No.	Description	Max Fee (excl. GST)
90092	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of not more than 5 minutes in duration an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$21.90
90093	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$41.30
90095	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$91.60
90096	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes, but less than 60 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient (subject to Clause 2.30.1), by a medical practitioner who is not a general practitioner	$148.40
90183	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting not more than 5 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1 (2))	$41.50
90188	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting more than 5 minutes but not more than 25 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1 (2))	$90.40
90202	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting more than 25 minutes but not more than 45 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1 (2))	$175.40
90212	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes but not more than 60 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1 (2))	$258.20
90215	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 60 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1 (2))	$418.30

SCHEDULE 1B

Scale of Charges—Other Medical Services

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

- printed on A4 size paper
- addressed specifically to the report requestor
- all margins to be no more than 2.5cms
- line spacing of no more than 1.5 lines
- font size no more than 12pt
- signed by the provider of the report.

Item No.	Description	Max Fee (excl. GST)
RECOVERY AND RETURN TO WORK PLANS		
RRTWG	General practitioners: reviewing and signing of a recovery and return to work plan, expected to be provided within 10 business days of receipt of the initial request.	$82.70 flat fee
RRTWR	Consultant physicians, specialists in a surgical discipline: reviewing and signing of a recovery and return to work plan, expected to be provided within 10 business days of receipt of the initial request.	$162.30 flat fee
Note 1:	A Recovery and return to work plan must be requested by: - a claims manager or self-insured employer - a worker's employer (including the employer's return to work coordinator) - an approved return to work service provider.	
Note 2:	The date of request is taken to be two business days after the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
Note 3:	Payment will only be made following submission of the signed plan.	
SHORT MEDICAL REPORT—TREATING DOCTOR		
WMG37	General practitioners: Short medical report, expected to be provided within 3 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$127.20 flat fee
WMP37	Consultant physicians: Short medical report, expected to be provided within 3 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$162.30 flat fee
WMS37	Specialists in a surgical discipline: Short medical report expected to be provided within 3 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$162.30 flat fee
Note 1:	A short medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.	
Note 2:	The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
Note 3:	If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
Note 4:	A short report should be 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 latter.	$330.90 flat fee
WMP16	Consultant physicians: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$620.10 flat fee
WMS16	Specialists in a surgical discipline: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$620.10 flat fee

Item No.	Description	Max Fee (excl. GST)

Note 1: A standard medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.

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

Note 5: Payment will only be made following submission of the report.

COMPLEX MEDICAL REPORT—TREATING DOCTOR(EXCLUDING PSYCHIATRISTS)

WMG40	General practitioners: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$413.60 flat fee
WMP40	Consultant physicians: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$777.50 flat fee
WMS40	Specialists in a surgical discipline: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$777.50 flat fee

Note 1: A complex medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer, - worker, worker's representative or advocate.

Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.

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

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

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

STANDARD MEDICAL REPORT—TREATING PSYCHIATRIST

WMY43	Psychiatrists: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the latter.	$777.50 flat fee

Note 1: A standard medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer, - worker, worker's representative or advocate.

Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.

Note 4: A standard medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item 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 latter.	$967.60 flat fee

Item No.	Description	Max Fee (excl. GST)
Note 1:	A complex medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer, - worker, worker's representative or advocate.	
Note 2:	The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
Note 3:	If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
Note 4:	A complex medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item number WMY73. Consultation items in Schedule 1A must not be used for this purpose.	
Note 5:	Payment will only be made following submission of the report.	
CONSULTATION, MEDICAL REVIEW FOR PREPARATION OF A REPORT—TREATING DOCTOR		
WMG70	General Practitioner: Consultation: medical review for the preparation of a treating doctor report.	$75.70 flat fee
WMP70	Consultant Physicians: Consultation: medical review for the preparation of a treating doctor report.	$151.70 flat fee
WMS70	Specialist in a surgical discipline: Consultation: medical review for the preparation of a treating doctor report.	$151.70 flat fee
WMY73	Psychiatrists: Consultation: medical review for the preparation of a treating doctor report.	$421.10 flat fee
READING TIME TO PREPARE A REPORT—TREATING DOCTOR		
WMG55	DERIVED FEE, General practitioners: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMG55 is $75.70 for reading time up to and including 12 pages, plus $6.50 per page thereafter.	DF
WMP55	DERIVED FEE, Consultant physicians: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMP55 is $151.70 for reading time up to and including 12 pages, plus $12.00 per page thereafter.	DF
WMS55	DERIVED FEE, Specialists in a surgical discipline: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMS55 is $151.70 for reading time up to and including 12 pages, plus $12.00 per page thereafter.	DF
WMY55	DERIVED FEE, Psychiatrists: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMY55 is $197.00 for reading time up to and including 12 pages, plus $12.00 per page thereafter.	DF
Note 1:	Payment for reading of written material will only be made where the reading is required in order for the doctor to prepare a report, and where the reading is at the request or approval of a: - claims manager or self-insured employer - worker, worker's representative or advocate.	
Note 2:	A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1.	
Note 3:	A full page for reading time consists of a whole A4 size page of standard print (12 point font or smaller) of information, full page letters and detailed reports. Examples include: hospital treatment notes, medical reports, investigation reports. A half page of reading time consists of half an A4 page or a full A5 size page of standard print (12 point font or smaller) of information, brief file notes, scattered file notes on a page, letters consisting of one or two paragraphs, results and certificates. Examples include: pathology results, notice of disability, full page of handwritten notes.	
Note 4:	The reading of material supplied by the requestor can only be charged once. No additional charge can be submitted for re-reading of material.	
MEDICAL REPORT CLARIFICATION—TREATING DOCTOR		
WMG25	General practitioners: Clarification of a medical report, re-examination not required.	$74.40 flat fee
WMP25	Consultant physicians: Clarification of a medical report, re-examination not required.	$135.40 flat fee
WMS25	Specialists in a surgical discipline: Clarification of a medical report, re-examination not required.	$135.40 flat fee
Note 1:	Clarification of a medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.	
Note 2:	The requestor must specify that he or she is seeking a clarification of a previous medical report.	
Note 3:	A medical report clarification fee is not payable if the clarification is sought as a result of failure by the doctor to address the original questions in the letter of request.	
Note 4:	Payment will only be made following submission of the report.	
TELEPHONE CALL(EXCLUDING CALLS MADE TO OR RECEIVED FROM INJURED WORKERS)		
WMG24	General practitioners: Telephone call up to and including 60 minutes duration.	$330.90 per hour

Item No.	Description	Max Fee (excl. GST)
WMP24	Consultant physicians: Telephone call up to and including 60 minutes duration.	$648.50 per hour
WMS24	Specialists in a surgical discipline: Telephone call up to and including 60 minutes duration.	$648.50 per hour

Note 1: Telephone calls are chargeable if related to the management of the worker's claim, or to progress their recovery and return to work, made to or received from: - a claims manager or self-insured employer - a worker's employer (including the employer's return to work co-ordinator) - a worker's representative or advocate - a ReturnToWorkSA medical advisor - an approved return to work service provider - a worker's referring/treating practitioner.

Note 2: There is no charge for a telephone call to or from a worker.

Note 3: A fee is payable if the telephone contact occurs during a consultation with the worker provided that the consultation duration excludes the duration of the telephone call. For example, if the consultation and telephone call duration is 20 minutes and the call duration alone is 10 minutes, the consultation should be charged as a 10 minute consultation.

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

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

CASE CONFERENCE

WMG09	General practitioners: Case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker's recovery, including medical treatment strategies.	$330.90 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.	$648.50 per hour
WMS09	Specialists in a surgical discipline: Case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker's recovery, including medical treatment strategies.	$648.50 per hour

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

Note 2: The claims manager or self-insured employer should attend the case conference if at all possible. If the claims manager or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by any medical practitioner during the case conference unless delegated as the representative by the claims manager or self-insured employer. It is the responsibility of the claims manager, self-insured employer or delegated representative to make a written and signed record of the case conference that is to be distributed to all attendees. Differences of opinion should be noted in the record. The worker or worker's representative must always be invited to attend the case conference.

Note 3: Case conferences conducted by telephone (teleconferencing) are chargeable under this item.

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

WORKSITE ASSESSMENT

WMG08	General practitioners: Worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties.	$330.90 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.	$648.50 per hour
WMS08	Specialist in a surgical discipline: Worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties.	$648.50 per hour

Note 1: A worksite assessment may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: At worksite visits it is expected that the employer, worker or worker's representative, claims manager or self-insured employer representative should be present.

Note 3: The claims manager or self-insured employer should contact the employer to ensure appropriate access to the worksite and to arrange for an employer representative to be available to help maximise the value of time spent in the workplace.

Note 4: The worksite assessment must include an assessment of the physical environment, mental work demands, human behaviour, working conditions, educational requirements and other conditions.

Note 5: The report of a worksite assessment is to be completed and distributed by the medical practitioner undertaking the assessment to relevant parties in attendance during the worksite assessment. A copy must also be provided to the claims manager, treating doctor and worker (if not present) within one week of the assessment. No additional fee is payable for completion of the form.

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

THIRD PARTY CONSULTATION

WMG14	General practitioners: Third party consultation at the doctor's rooms where the worker is usually not present.	$330.90 per hour
WMP14	Consultant physicians: Third party consultation at the doctor's rooms where the worker is usually not present.	$648.50 per hour
WMS14	Specialists in a surgical discipline: Third party consultation at the doctor's rooms where the worker is usually not present.	$648.50 per hour

Item No.	Description	Max Fee (excl. GST)

Note 1: A third party consultation must involve at least one of the following: - claims manager or self-insured employer - worker, worker's representative or advocate - worker's employer (including the employer's rehabilitation and return to work co-ordinator) - investigator - approved return to work service provider.

Note 2: A third party consultation may include a video viewing of a worker's normal duties, alternative duties or other activities.

Note 3: It is the responsibility of the claims manager or self-insured employer to ensure a written and signed record is made of the third party consultation that is to be distributed to all attendees. No fee is payable for records made by any medical practitioner during the third party consultation.

Note 4: If as a result of the third party consultation the medical practitioner has amended details regarding the worker's limitations to work, capacity, recommendations for facilitating a return to work and/or options for management of the worker, the medical practitioner must consider the worker's input into this decision.

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

ATTENDANCE AT A DISPUTE RESOLUTION

WMG15	General practitioners: Attendance at a dispute resolution.	$330.90 per hour
WMP15	Consultant physicians: Attendance at a dispute resolution.	$648.50 per hour
WMS15	Specialists in a surgical discipline: Attendance at a dispute resolution.	$648.50 per hour

Note 1: Attendance at a dispute resolution must be at the request of a: - claims manager or self-insured employer - worker, worker's representative or advocate - worker's employer or employer's representative.

Note 2: Court attendances can be charged under this item.

Note 3: A witness at a dispute resolution proceeding is entitled to reimbursement of any expense that the dispute resolution authority certifies has been, or is likely to be, reasonably incurred by the witness as a consequence of appearing before the authority.

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

TRAVEL TIME: WORKSITE ASSESSMENT, CASE CONFERENCE, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION

WMG10	General practitioners: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$330.90 per hour
WMP10	Consultant physicians: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$648.50 per hour
WMS10	Specialists in a surgical discipline: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$648.50 per hour

Note 1: All accounts must include the total time spent travelling plus the distance travelled.

Note 2: Where more than one worksite assessment, case conference or dispute resolution is conducted, the travel fee is to be apportioned accordingly.

Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

CANCELLATION: CASE CONFERENCE, WORKSITE ASSESSMENT, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION

WMG36	General practitioners: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$330.90 per hour
WMP36	Consultant physicians: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$648.50 per hour
WMS36	Specialists in a surgical discipline: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$648.50 per hour

Note 1: Payment for cancellation will only be made when the attendance was at the request of a: - claims manager or self-insured employer - worker, worker's representative or advocate - employer or employer's representative.

Note 2: A cancellation fee is payable only if the cancellation occurs less than 48 hours (excluding weekends and public holidays in South Australia) before the time of the proposed attendance.

Note 3: A cancellation fee is not payable if the doctor is responsible for the cancellation.

Note 4: If the cancelled appointment is subsequently filled with any other earning activity, no cancellation fee will be payable.

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

JOB ANALYSIS AND/OR RECOMMENDED JOB DESCRIPTION STATEMENT

WMG56	General practitioners: Formal job analysis and/or recommended job descriptions. Reading of and written recommendations on the suitability of proposals for return to work, expected to be provided within 10 business days of receipt of the initial request.	$127.20 flat fee
WMP56	Consultant physicians: Formal job analysis and/or recommended job descriptions. Reading of and written recommendations on the suitability of proposals for return to work, expected to be provided within 10 business days of receipt of the initial request.	$162.30 flat fee

Item No.	Description	Max Fee (excl. GST)
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.	$162.30 flat fee

Note 1: A job analysis and/or job description statement must be requested in writing and may be requested by: - a claims manager or self-insured employer - a worker, worker's representative or advocate - an approved return to work service provider.

Note 2: The date of request is taken to be two business days after the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

SPECIFIED DUTIES FORM

WMG23	General practitioners: Completion of a specified duties form.	$29.10 flat fee
WMP23	Consultant physicians: Completion of a specified duties form.	$29.10 flat fee
WMS23	Specialist in a surgical discipline: Completion of a specified duties form.	$29.10 flat fee

Note 1: This form is to be completed at the request of a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: A fee is not payable if the form is completed during a consultation with the worker.

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

PHOTOCOPYING

WMADM	General practitioners, consultant physicians, specialists in a surgical discipline: Administration fee for the time to prepare and provide requested documents, and radiology, including postage. This may include where applicable, scanning and saving documents to a device (e.g. USB, disc), including the cost of the device.	$88.20 flat fee
WMGSP	General practitioners, consultant physicians, specialists in a surgical discipline: Photocopying of medical notes, reports and results of relevant tests e.g. pathology, diagnostic imaging reports. This service includes photocopying/printing costs only. In addition to photocopying, item WMADM can be billed as an administration cost. Note: Where documents are provided via media (e.g. USB, disc, email), only the administration fee applies.	$0.30

Note 1: A fee is only payable if the photocopying is at the request of a: - claims manager or self-insured employer - worker, worker's representative or advocate - investigator.

Note 2: The number of pages should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.

Note 3: Accounts must state the name of the doctor providing the photocopied information. Accounts with the practice name only will be returned for amendment.

TRAVEL TIME—EMERGENCY ATTENDANCE

WMG58	General practitioners: Travel time, for the purpose of an initial emergency attendance of a compensable injury, at a location other than consulting rooms, hospital or other healthcare institution, when ambulance services are either not readily available or unduly delayed.	$330.90 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.	$481.30 per hour

Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.

Note 2: All invoices must include the distance travelled, the travel commencement location, place of emergency attendance and a brief reason for the attendance.

Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

TRAVEL TIME—EMERGENCY RETRIEVAL TEAM

WMS51	Specialists: Travel time by a retrieval team doctor in association with a professional attendance relating to item numbers 00160, 00161, 00162, 00163 and 00164, other than 'out of hours' travel (refer to item number WMS52).	$648.50 per hour
WMS52	Specialists: Travel time by a retrieval team doctor on a Sunday, public holiday in South Australia, after 1pm on Saturday or between 8pm and 8am on weekdays, in addition to a professional attendance relating to item numbers 00160, 00161, 00162, 00163 and 00164.	$939.70 per hour

Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.

Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.

EXTRA-CORPOREAL SHOCK WAVE THERAPY

WMI11	Specialists: Initial treatment of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$185.10 flat fee
WMI12	Specialists: Subsequent treatments of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$151.70 flat fee

Item No.	Description	Max Fee (excl. GST)
WMI13	Specialists: Double treatments (bilateral or multiple) of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$252.60 flat fee

Note 1: The I in prefix WMI item number represents the letter 'I' not a numeral one (1).

Note 2: This treatment has been approved by ReturnToWorkSA for use in the following conditions: - heel pain/plantar fasciitis - calcific tendonitis of shoulder - lateral epicondylitis (tennis elbow) - medial epicondylitis - non-united fractures - patellar tendinopathy.

Note 3: Where Extra-Corporeal Shock Wave Therapy is delivered outside of the approved conditions it is recommended to seek claims manager authorisation prior to the provision of the service.

Note 4: Epicondylitis treatment is NOT payable by ReturnToWorkSA for treatment provided within three months or after five years from date of injury.

SERVICES DELIVERED BY EAR, NOSE AND THROAT SURGEONS

WME24	Otorhinolaryngologists: Cortical evoked response audiometry - verification.	$431.80 flat fee
WME25	Otorhinolaryngologists: Sensonics smell identification test.	$187.70 flat fee
WME2A	Otorhinolaryngologists: Cortical evoked response audiometry - quantification.	$431.80 flat fee

SERVICES DELIVERED BY MEDICAL PRACTITIONERS

WMG26	Medical practitioners: Fluids, intravenous drip infusion of - percutaneous.	$74.20 flat fee
WMG27	Medical Practitioners: Fluids, intravenous drip infusion of - open exposure.	$123.20 flat fee

Note 1: Item WMG26 is only payable where the service is not in association with a surgical procedure.

SERVICES DELIVERED BY MEDICAL PRACTITIONERS IN THE PRACTICE OF HYPNOTHERAPY

WMG28	Hypnotherapy at consulting rooms, 16 to 30 minutes.	$110.60 flat fee
WMG29	Hypnotherapy at consulting rooms, 31 to 45 minutes.	$166.10 flat fee
WMG30	Hypnotherapy at consulting rooms, more than 46 minutes.	$226.20 flat fee
WMG31	Hypnotherapy at consulting rooms, not more than 15 minutes.	$64.00 flat fee

INDEPENDENT MEDICAL EXAMINER—DESKTOP REVIEW MEDICAL REPORT(EXCLUDING PSYCHIATRISTS)

WMP29	Consultant physicians: Independent medical examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by more than one consultant physician/specialist. The report is expected to be provided within 10 business days of receipt of the initial request.	$777.50 flat fee
WMS29	Specialists in a surgical discipline: Independent medical examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by more than one consultant physician/specialist. The report is expected to be provided within 10 business days of receipt of the initial request.	$777.50 flat fee

Note 1: A medical report based on a review of documentation is only for situations such as where there are two or more opposing medical opinions; clarification is sought regarding a point or points where the original examiner is unavailable, or to obtain an expert opinion, with a view to introducing the expert to give evidence in legal proceedings.

Note 2: A medical report based on a review of documentation must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 3: Documentation can include information such as medical reports/information from professionals such as a consultant physicians, specialists, hospital doctors; hospital records; prescriptions, and other relevant information, such as x-rays, MRIs, CT Scans, and test results. Time spent reading documentation can be charged using WMP82.

Note 4: The date of request is taken to be 2 business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

Note 5: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the requestor and clarified.

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

INDEPENDENT DENTAL EXAMINER—DESKTOP REVIEW DENTAL REPORT

WMD29	Dentist: Independent dental examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by at least one dentist. The report is expected to be provided within 10 business days of receipt of the initial request.	$777.50 flat fee

Note 1: A dental report based on a review of documentation is only for situations such as where there are two or more opposing dental opinions; clarification is sought regarding a point or points where the original examiner is unavailable, or to obtain an expert opinion, with a view to introducing the expert to give evidence in legal proceedings. This is not for use where a supplementary report has been requested.

Note 2: A dental report based on a review of documentation must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 3: Documentation can include information such as dental/medical reports/information from professionals such as a consultant physicians, specialists, hospital doctors; hospital records; prescriptions, and other relevant information, such as x-rays, CT Scans, and test results. Time spent reading documentation can be charged using WMD82.

Item No.	Description	Max Fee (excl. GST)

Note 4: The date of request is taken to be 2 business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

Note 5: If a dental practitioner believes the incorrect report type has been requested, this should be referred back to the requestor and clarified.

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

INDEPENDENT MEDICAL EXAMINER—PSYCHIATRISTS DESKTOP REVIEW MEDICAL REPORT

WMY61	Psychiatrists: Independent medical examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by more than one consultant physician/specialist. The report is expected to be provided within 10 business days of receipt of the initial request.	$967.60 flat fee

Note 1: A medical report based on a review of documentation is only for situations such as where there are two or more opposing medical opinions; clarification is sought regarding a point or points where the original examiner is unavailable, or to obtain an expert opinion, with a view to introducing the expert to give evidence in legal proceedings.

Note 2: A medical report based on a review of documentation must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 3: Documentation can include information such as medical reports/information from professionals such as a consultant physicians, specialists, hospital doctors; hospital records; prescriptions, and other relevant information, such as x-rays, MRIs, CT Scans, and test results. Time spent reading documentation can be charged using WMY90.

Note 4: The date of request is taken to be 2 business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.

Note 5: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the requestor and clarified.

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

INDEPENDENT MEDICAL EXAMINER—SUPPLEMENTARY MEDICAL REPORT

WMP33	Consultant physicians: Supplementary medical report, where additional information or clarification is requested or by the report requestor, re-examination not required. A supplementary report fee is not payable if the report is requested as a result of an error, omission or failure by the medical practitioner to address the original questions in the letter of request.	$324.20 flat fee
WMS33	Specialists in a surgical discipline: Supplementary medical report, where additional information or clarification is requested or by the report requestor, re-examination not required. A supplementary report fee is not payable if the report is requested as a result of an error, omission or failure by the medical practitioner to address the original questions in the letter of request.	$324.20 flat fee

Note 1: A supplementary medical report must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: The requestor must specify that they are seeking a supplementary report relating to a previous medical report.

Note 3: The intention of this fee is to provide facilities for follow up questions or issues relating to prior independent medical examinations and additional consultations may not be required.

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

INDEPENDENT DENTAL EXAMINER—SUPPLEMENTARY DENTAL REPORT

WMD33	Dentist: Supplementary dental report, where additional information is requested by the report requestor, re-examination not required. A supplementary report fee is not payable if the report is requested as a result of an error, omission or failure by the dental practitioner to address the original questions in the letter of request.	$324.20 flat fee

Note 1: A supplementary dental report must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: The requestor must specify that they are seeking a supplementary report relating to a previous dental report.

Note 3: The intention of this fee is to provide facilities for follow up questions or issues relating to prior independent dental examinations and additional consultations may not be required.

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

INDEPENDENT MEDICAL EXAMINER—TRAVEL TIME: WORKSITE ASSESSMENT, CASE CONFERENCE, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION

MP940	Consultant physicians: Independent medical examiner travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$648.50 per hour
MS940	Specialists in a surgical discipline: Independent medical examiner travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$648.50 per hour

Note 1: Travel will be approved for independent medical examiner services requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: All accounts must include the total time spent travelling as well as the distance travelled.

Note 3: Where more than one service is conducted, the travel fee is to be apportioned accordingly.

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

Item No.	Description	Max Fee (excl. GST)
INDEPENDENT MEDICAL EXAMINER—NON-ATTENDANCE OR CANCELLATION OF AN APPOINTMENT		
WMP34	Consultant physicians: Independent medical examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public hospitals in South Australia) before an appointment.	$648.50 flat fee
WMS34	Specialists in a surgical discipline: Independent medical examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment.	$648.50 flat fee
WMY88	Psychiatrists: Independent medical examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment.	$648.50 flat fee
Note 1: Fees apply only to the cancellation of medical appointments arranged by a: - claims manager or self-insured employer - worker, worker's representative or advocate.		
Note 2: If the cancelled appointment or non-attendance is subsequently filled with any other earning activity, no cancellation fee will be payable.		
INDEPENDENT DENTAL EXAMINER—NON-ATTENDANCE OR CANCELLATION OF AN APPOINTMENT		
WMD34	Dentist: Independent dental examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public hospitals in South Australia) before an appointment.	$648.50 flat fee
Note 1: Fees apply only to the cancellation of dental appointments arranged by a: - claims manager or self-insured employer - worker, worker's representative or advocate.		
Note 2: If the cancelled appointment or non-attendance is subsequently filled with any other earning activity, no cancellation fee will be payable.		
INDEPENDENT MEDICAL EXAMINER—TRAVEL FOR EXAMINATIONS		
WMP64	Consultant physicians: Independent medical examiner, a full day attendance at the venue more than 100 kilometres from the Adelaide GPO for the purpose of providing an independent medical examiner report.	$189.70 flat fee
WMP65	Consultant physicians: Independent medical examiner cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$303.40 flat fee
WMP66	Consultant physicians: Independent medical examiner overnight accommodation including meals and incidentals.	$401.80 flat fee
WMP67	Consultant physicians: Independent medical examiner travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor.	ATO rates
WMP68	Consultant physicians: Independent medical examiner travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor.	Economy airfare
WMS64	Specialists in a surgical discipline: Independent medical examiner, a full day attendance at a venue more than 100 kilometres from the Adelaide GPO for the purpose of providing an independent medical examiner report.	$189.70 flat fee
WMS65	Specialists in a surgical discipline: Independent medical examiner cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$303.40 flat fee
WMS66	Specialists in a surgical discipline: Independent medical examiner overnight accommodation including meals and incidentals.	$401.80 flat fee
WMS67	Specialists in a surgical discipline: Independent medical examiner travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor.	ATO rates
WMS68	Specialists in a surgical discipline: Independent medical examiner travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor.	Economy airfare
Note 1: The first 50 kilometres of any travel is not billable.		
Note 2: If more than one organisation has requested services from the provider at the travel destination then items WMP/S64, WMP/S66, WMP/S67 and/or WMP/S68 must be apportioned accordingly.		
Note 3: A full day pursuant to item WMP/S64 refers to a stay of more than 6 hours at the venue including travel time.		
Note 4: ATO rates means the rate, applicable to the type of motor vehicle in which the medical expert travelled, published by the Australian Taxation Office as the rate per kilometre that may be claimed as a deduction for business travel expenses incurred in the previous financial year.		
Note 5: Economy airfare means the amount determined by ReturnToWorkSA to be the reasonable cost of undertaking the travel using a standard economy airfare.		
INDEPENDENT MEDICAL EXAMINER—TELEPHONE CALL		
AIMP24	Consultant physicians: Independent medical examiner telephone call (excluding calls made to or received from injured workers), up to and including 60 minutes duration.	$648.50 per hour
AIMS24	Specialists in a surgical discipline: Independent medical examiner telephone call (excluding calls made to or received from injured workers), up to and including 60 minutes duration.	$648.50 per hour

Item No.	Description	Max Fee (excl. GST)

Note 1: Telephone calls are chargeable if related to the management of the worker's claim, or to progress their recovery and return to work, made to or received from: - a claims manager or self-insured employer, - a worker's employer (including the employer's return to work co-ordinator), - a worker's representative or advocate, - a ReturnToWorkSA medical advisor, - an approved return to work service provider, - a worker's referring/treating practitioner.

Note 2: There is no charge for a telephone call to or from a worker.

Note 3: A fee is payable if the telephone contact occurs during a consultation with the worker provided that the consultation duration excludes the duration of the telephone call. For example, if the consultation and telephone call duration is 20 minutes and the call duration alone is 10 minutes, the consultation should be charged as a 10 minute consultation.

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

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

INDEPENDENT MEDICAL EXAMINER—CASE CONFERENCE

AIMP09	Consultant physicians: Independent medical examiner case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker's recovery, including medical treatment strategies.	$648.50 per hour
AIMS09	Specialists in a surgical discipline: Independent medical examiner case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker's recovery, including medical treatment strategies.	$648.50 per hour

Note 1: A case conference may be requested by: - a claims manager or self-insured employer, - a worker's employer (including the employer's return to work co-ordinator), - a worker or worker's representative, - an approved return to work service provider, - a treating medical expert.

Note 2: The claims manager or self-insured employer should attend the case conference if at all possible. If the claims manager or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by any medical practitioner during the case conference unless delegated as the representative by the claims manager or self-insured employer. It is the responsibility of the claims manager, self-insured employer or delegated representative to make a written and signed record of the case conference that is to be distributed to all attendees. Differences of opinion should be noted in the record. The worker or worker's representative must always be invited to attend the case conference.

Note 3: Case conferences conducted by telephone (teleconferencing) are chargeable under this item.

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

INDEPENDENT MEDICAL EXAMINER—WORKSITE ASSESSMENT

AIMP08	Consultant physicians: Independent medical examiner worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties.	$648.50 per hour
AIMS08	Specialists in a surgical discipline: Independent medical examiner worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties.	$648.50 per hour

Note 1: A worksite assessment may be requested by a: - claims manager or self-insured employer, - worker, worker's representative or advocate.

Note 2: At worksite visits it is expected that the employer, worker or worker's representative, claims manager or self-insured employer representative should be present.

Note 3: The claims manager or self-insured employer should contact the employer to ensure appropriate access to the worksite and to arrange for an employer representative to be available to help maximise the value of time spent in the workplace.

Note 4: The worksite assessment must include an assessment of the physical environment, mental work demands, human behaviour, working conditions, educational requirements and other conditions.

Note 5: The report of a worksite assessment is to be completed and distributed by the medical practitioner undertaking the assessment to relevant parties in attendance during the worksite assessment. A copy must also be provided to the claims manager, treating doctor and worker (if not present) within one week of the assessment. No additional fee is payable for completion of the form.

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

INDEPENDENT MEDICAL EXAMINER—THIRD PARTY CONSULTATION

AIMP14	Consultant physicians: Independent medical examiner third party consultation at the doctor's rooms where the worker is usually not present.	$648.50 per hour
AIMS14	Specialists in a surgical discipline: Independent medical examiner third party consultation at the doctor's rooms where the worker is usually not present.	$648.50 per hour

Note 1: A third party consultation must involve at least one of the following: - claims manager or self-insured employer, - worker, worker's representative or advocate, - worker's employer (including the employer's return to work co-ordinator), - investigator, - approved return to work service provider.

Note 2: A third party consultation may include a video viewing of a worker's normal duties, alternative duties or other activities.

Item No.	Description	Max Fee (excl. GST)

Note 3: It is the responsibility of the claims manager or self-insured employer to ensure a written and signed record is made of the third party consultation that is to be distributed to all attendees. No fee is payable for records made by any medical practitioner during the third party consultation.

Note 4: If as a result of the third party consultation the medical practitioner has amended details regarding the worker's limitations to work, capacity, recommendations for facilitating a return to work and/or options for management of the worker, the medical practitioner must consider the worker's input into this decision.

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

INDEPENDENT MEDICAL EXAMINER—ATTENDANCE AT A DISPUTE RESOLUTION

AIMP15	Consultant physicians: Independent medical examiner attendance at a dispute resolution.	$648.50 per hour
AIMS15	Specialists in a surgical discipline: Independent medical examiner attendance at a dispute resolution.	$648.50 per hour

Note 1: Attendance at a dispute resolution must be at the request of a: - claims manager or self-insured employer, - worker, worker's representative or advocate, - worker's employer or employer's representative.

Note 2: Court attendances can be charged under this item.

Note 3: A witness at a dispute resolution proceeding is entitled to reimbursement of any expense that the dispute resolution authority certifies has been, or is likely to be, reasonably incurred by the witness as a consequence of appearing before the authority.

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

INDEPENDENT MEDICAL EXAMINATION—CANCELLATION OF A CASE CONFERENCE, WORKSITE ASSESSMENT, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION

AIMP36	Consultant physicians: Independent medical examiner cancellation of a case conference, worksite assessment, dispute resolution or third party consultation.	$648.50 per hour
AIMS36	Specialists in a surgical discipline: Independent medical examiner cancellation of a case conference, worksite assessment, dispute resolution or third party consultation.	$648.50 per hour

Note 1: Payment for cancellation will only be made when the attendance was at the request of a: - claims manager or self-insured employer, - worker, worker's representative or advocate, - employer or employer's representative.

Note 2: A cancellation fee is payable only if the cancellation occurs less than 48 hours (excluding weekends and public holidays in South Australia) before the time of the proposed attendance.

Note 3: A cancellation fee is not payable if the doctor is responsible for the cancellation.

Note 4: If the cancelled appointment is subsequently filled with any other earning activity, no cancellation fee will be payable.

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

INDEPENDENT MEDICAL EXAMINER—REPORT, EXAMINATION AND READING

WMP28	Consultant physicians: Independent medical examiner report inclusive of the physical examination, reading up to 100 pages, and report writing - expected to be provided within 10 business days of the examination.	$1,750.30 flat fee
WMS28	Specialists in a Surgical discipline: Independent medical examiner report inclusive of the physical examination, reading up to 100 pages, and report writing - expected to be provided within 10 business days of the examination.	$1,750.30 flat fee
WMY60	Psychiatrists: Independent medical examiner report inclusive of the examination, reading up to 100 pages, and report writing - expected to be provided within 10 business days of the examination.	$1,940.30 flat fee

Note 1: The independent medical examination must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: The independent medical examination report fee includes the physical examination and reading of up to 100 pages.

Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary.

Note 4: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.

Note 5: Payment will only be made following submission of the report.

INDEPENDENT DENTAL EXAMINER—REPORT, EXAMINATION AND READING

WMD28	Dentist: Independent dental examiner report inclusive of the physical examination, reading up to 100 pages, and report writing - expected to be provided within 10 business days of the examination.	$1,750.30 flat fee

Note 1: The independent dental examination must be requested in writing and may be requested by a: - claims manager or self-insured employer - worker, worker's representative or advocate.

Note 2: The independent dental examination report fee includes the examination and reading of up to 100 pages.

Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary.

Item No.	Description	Max Fee (excl. GST)
Note 4: If a dental practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.		
Note 5: Payment will only be made following submission of the report.		
Note 6: Independent dental examination is inclusive of administrative costs but is not inclusive of imaging, dental assistant/nurse, sterilisation and other consumables.		
INDEPENDENT MEDICAL EXAMINER—ADDITIONAL READING TIME		
WMP82	Consultant physicians: Independent medical examiner additional reading time, payable when: - there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or - reading material is supplied in conjunction with a supplementary report (WMP33) or a medical report based upon review of documentation (WMP29), or - a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred.	$648.50 per hour Max 2 hours
WMS82	Specialists in a surgical discipline: Independent medical examiner additional reading time, payable when: - there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or - reading material is supplied in conjunction with a supplementary report (WMS33) or a medical report based upon review of documentation (WMS29), or - a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred.	$648.50 per hour Max 2 hours
WMY90	Psychiatrists: Independent medical examiner additional reading time, payable when: - there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or - reading material is supplied in conjunction with a medical report based upon review of documentation (WMY61), or - a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred.	$648.50 per hour Max 2 hours
Note 1: Payment for the reading of written material will only be made where the reading is required for the medical practitioner to prepare a report, and where the reading is at the request or approval of a: - claims manager or self-insured employer, - worker, worker's representative or advocate.		
Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1.		
Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary.		
Note 4: ReturnToWorkSA expects that up to 200 pages are able to be read per hour.		
Note 5: The number of pages read should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.		
Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six 6 minutes.		
Note 7: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material.		
INDEPENDENT DENTAL EXAMINER—ADDITIONAL READING TIME		
WMD82	Dentist: Independent dental examiner additional reading time, payable when: - there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or - reading material is supplied in conjunction with a supplementary report (WMD33) or a dental report based upon review of documentation (WMD29) or - a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred.	$648.50 per hour Max 2 hours
Note 1: Payment for the reading of written material will only be made where the reading is required for the dental practitioner to prepare a report, and where the reading is at the request or approval of a: - claims manager or self-insured employer, - worker, worker's representative or advocate.		
Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in Note 1.		
Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary.		
Note 4: ReturnToWorkSA expects that up to 200 pages are able to be read per hour.		
Note 5: The number of pages read should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.		
Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.		
Note 7: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material.		

Permanent Impairment Assessments

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

Item No.	Description	Max Fee (excl. GST)
PERMANENT IMPAIRMENT ASSESSOR—STANDARD REPORT		
PIA10	General practitioners: permanent impairment assessor standard report, simple assessment of one body system combined with one body part - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$1,718.60 flat fee
PIA30	Specialists (excluding psychiatrists): permanent impairment assessor standard report, simple assessment of one body system combined with one body part - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$1,718.60 flat fee
PIA40	Psychiatrists: permanent impairment assessor standard report for the assessment of psychiatric disorders; assessment where there is one disorder or condition related to the work injury - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,148.10 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 6: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

PERMANENT IMPAIRMENT ASSESSOR—MODERATELY COMPLEX REPORT		
PIA11	General practitioners: permanent impairment assessor moderately complex report, simple assessment of: - one body system combined with two body parts - one body system combined with three body parts - two body systems combined with two body parts - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,148.40 flat fee
PIA31	Specialists: permanent impairment assessor moderately complex report, simple assessment of: - one body system combined with two body parts - one body system combined with three body parts - two body systems combined with two body parts - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,148.40 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: Corrections, amendments, and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 6: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

PERMANENT IMPAIRMENT ASSESSOR—COMPLEX REPORT		
PIA12	General practitioners: permanent impairment assessor complex report, complex assessment of: - one body system combined with four body parts - one body system combined with five body parts - two body systems combined with three body parts - two body systems combined with four body parts - three body systems combined with three body parts – reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,721.30 flat fee

Item No.	Description	Max Fee (excl. GST)
PIA32	Specialists (excluding psychiatrists): permanent impairment assessor complex report, complex assessment of: - one body system combined with four body parts - one body system combined with five body parts - two body systems combined with three body parts - two body systems combined with four body parts - three body systems combined with three body parts - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,721.30 flat fee
PIA42	Psychiatrists: permanent impairment assessor complex report for the assessment of psychiatric disorders or conditions; assessment where there is more than one disorder related to the work injury or pre-existing or non-work-related and/or neurological considerations - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,006.60 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 6: The lead assessor may only bill for the final complete report including the sub-assessor's report (s).

Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

PERMANENT IMPAIRMENT ASSESSOR—VERY COMPLEX REPORT

PIA20	General Practitioners: permanent impairment assessor very complex report, assessment of: - One body system combined with six body parts - One body system combined with seven body parts - Two body systems combined with five body parts - Two body systems combined with six body parts - Three body systems combined with four body parts - Three body systems combined with five body parts - Four body systems combined with four body parts - or lead assessor report - including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,488.70 flat fee
PIA70	Specialists (excluding psychiatrists): permanent impairment assessor very complex report, assessment of: - One body system combined with six body parts - One body system combined with seven body parts - Two body systems combined with five body parts - Two body systems combined with six body parts - Three body systems combined with four body parts - Three body systems combined with five body parts - Four body systems combined with four body parts - or lead assessor report - including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,488.70 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 6: The lead assessor may only bill for the final complete report including the sub-assessor's report(s).

Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

PERMANENT IMPAIRMENT ASSESSOR—HIGHLY COMPLEX REPORT

PIA21	General Practitioners: permanent impairment assessor highly complex report, assessment of: - One body system combined with eight body parts - One body system combined with nine body parts - Two body systems combined with seven body parts - Two body systems combined with eight body parts - Three body systems combined with six body parts - Three body systems combined with seven body parts - Four body systems combined with five body parts - Four body systems combined with six body parts - Five body systems combined with five body parts including reading up to 100 pages, examination, and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,973.20 flat fee

Item No.	Description	Max Fee (excl. GST)
PIA71	Specialists (excluding psychiatrists): permanent impairment assessor highly complex report, assessment of: - One body system combined with eight body parts - One body system combined with nine body parts - Two body systems combined with seven body parts - Two body systems combined with eight body parts - Three body systems combined with six body parts - Three body systems combined with seven body parts - Four body systems combined with five body parts - Four body systems combined with six body parts - Five body systems combined with five body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,973.20 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 6: The lead assessor may only bill for the final complete report including the sub-assessor's report (s).

Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

PERMANENT IMPAIRMENT ASSESSOR—ENT REPORT

PIA50	ENT specialists: permanent impairment assessor ENT report - reading up to 100 pages, examination of ear, nose and/or throat only, including audiometric testing and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$1,718.60 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

PERMANENT IMPAIRMENT ASSESSOR—STANDARD REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER

PIA13	General practitioners: permanent impairment assessor standard report with interpreter, simple assessment of one body system combined with one body part - reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,148.40 flat fee
PIA33	Specialists (excluding psychiatrists): permanent impairment assessor standard report with interpreter, simple assessment of one body system combined with one body part - reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,148.40 flat fee
PIA43	Psychiatrists: permanent impairment assessor standard report with interpreter, for the assessment of psychiatric disorders; assessment where there is one disorder or condition related to the work injury - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,684.90 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

Item No.	Description	Max Fee (excl. GST)
PERMANENT IMPAIRMENT ASSESSOR—MODERATELY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA14	General practitioners: permanent impairment assessor moderately complex report with interpreter, simple assessment of: - one body system combined with two body parts - one body system combined with three body parts - two body systems combined with two body parts - reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,578.00 flat fee
PIA34	Specialists: permanent impairment assessor moderately complex report with interpreter, simple assessment of: - one body system combined with two body parts - one body system combined with three body parts - two body systems combined with two body parts - reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,578.00 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

PERMANENT IMPAIRMENT ASSESSOR—COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA15	General practitioners: permanent impairment assessor complex report with interpreter, complex assessment of: - one body system combined with four body parts - one body system combined with five body parts - two body systems combined with three body parts - two body systems combined with four body parts - three body systems combined with three body parts – or lead assessor report - reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,150.90 flat fee
PIA35	Specialists (excluding psychiatrists): permanent impairment assessor complex report with interpreter, complex assessment of: - one body system combined with four body parts - one body system combined with five body parts - two body systems combined with three body parts - two body systems combined with four body parts - three body systems combined with three body parts - or lead assessor report - reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,150.90 flat fee
PIA45	Psychiatrists: permanent impairment assessor complex report, with interpreter, for the assessment of psychiatric disorders; assessment where there is more than one disorder related to the work injury or pre-existing or non-work-related and/or neurological considerations - reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,758.50 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 7: The lead assessor may only bill for the final complete report including the sub-assessor's report (s).

Note 8: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

Item No.	Description	Max Fee (excl. GST)
PERMANENT IMPAIRMENT ASSESSOR—VERY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA26	General Practitioners: permanent impairment assessor very complex report with interpreter, assessment of: - One body system combined with six body parts - One body system combined with seven body parts - Two body systems combined with five body parts - Two body systems combined with six body parts - Three body systems combined with four body parts - Three body systems combined with five body parts - Four body systems combined with four body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,900.90 flat fee
PIA76	Specialists (excluding psychiatrists): permanent impairment assessor very complex report with interpreter, assessment of: - One body system combined with six body parts - One body system combined with seven body parts - Two body systems combined with five body parts - Two body systems combined with six body parts - Three body systems combined with four body parts - Three body systems combined with five body parts - Four body systems combined with four body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$3,900.90 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 7: The lead assessor may only bill for the final complete report including the sub-assessor's report (s).

PERMANENT IMPAIRMENT ASSESSOR—HIGHLY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA27	General Practitioners: permanent impairment assessor highly complex report with interpreter, assessment of: - One body system combined with eight body parts - One body system combined with nine body parts - Two body systems combined with seven body parts - Two body systems combined with eight body parts - Three body systems combined with six body parts - Three body systems combined with seven body parts - Four body systems combined with five body parts - Four body systems combined with six body parts - Five body systems combined with five body parts including reading up to 100 pages, examination, and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$4,385.40 flat fee
PIA77	Specialists (excluding psychiatrists): permanent impairment assessor highly complex report with interpreter, assessment of: - One body system combined with eight body parts - One body system combined with nine body parts - Two body systems combined with seven body parts - Two body systems combined with eight body parts - Three body systems combined with six body parts - Three body systems combined with seven body parts - Four body systems combined with five body parts - Four body systems combined with six body parts - Five body systems combined with five body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$4,385.40 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

Note 7: The lead assessor may only bill for the final complete report including the sub-assessor's report (s).

Note 8: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.

Item No.	Description	Max Fee (excl. GST)
PERMANENT IMPAIRMENT ASSESSOR—ENT REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA51	ENT specialists: permanent impairment assessor ENT report with interpreter, reading up to 100 pages, examination of ear, nose and/or throat only, conducted with the assistance of an interpreter, including audiometric testing and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee.	$2,148.40 flat fee

Note 1: Reports will be requested by a claims manager or self-insured employer.

Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.

Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.

Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.

Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.

Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.

PERMANENT IMPAIRMENT ASSESSOR—CANCELLATION OF AN APPOINTMENT OR NON-ATTENDANCE		
PIA16	General practitioners: permanent impairment assessor non-attendance at, or cancellation with less than 2 business days' notice (excluding weekends or public holidays in South Australia) before an appointment.	$467.20 flat fee
PIA36	Specialists: permanent impairment assessor non-attendance at, or cancellation with less than 2 business days' notice (excluding weekends or public holidays) before an appointment	$467.20 flat fee

Note 1: A fee for a cancellation with more than 2 business days' notice (excluding weekends and public holidays in South Australia) is not payable.

Note 2: A fee for a cancellation or non-attendance does not apply if the appointment is subsequently filled with any other earning activity.

PERMANENT IMPAIRMENT ASSESSOR—SUPPLEMENTARY REPORT		
PIA17	General practitioners: permanent impairment assessor supplementary report, where additional information is requested by the report requestor. A supplementary report fee is not payable if additional work is required to respond to a clarification request from ReturnToWorkSA or a self-insured employer as a result of an error or omission on the part of the assessor.	$324.20 flat fee
PIA37	Specialists (including psychiatrists): permanent impairment assessor supplementary report, where additional information is requested by the report requestor. A supplementary report fee is not payable if additional work is required to respond to a clarification request from ReturnToWorkSA or a self-insured employer as a result of an error or omission on the part of the assessor.	$324.20 flat fee

Note 1: A supplementary report fee will only be paid where either ReturnToWorkSA, a claims manager, or a self-insured employer specifically requests a separate report that addresses matters that are additional to the original report request.

PERMANENT IMPAIRMENT ASSESSOR—TRAVEL FOR EXAMINATIONS		
PIA60	General practitioners or specialists (including psychiatrists): permanent impairment assessor travel, a full day attendance at a venue more than 100 kilometres from the Adelaide GPO for the purpose of providing a permanent impairment report.	$189.70 flat fee
PIA62	General practitioners or specialists (including psychiatrists): permanent impairment assessor - cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$303.40 flat fee
PIA64	General practitioners or specialists (including psychiatrists): permanent impairment assessor accommodation - overnight accommodation including meals and incidentals.	$401.80 flat fee
PIA66	General practitioners or specialists (including psychiatrists): permanent impairment assessor motor vehicle travel - travel by motor vehicle, to and from a venue for the purpose of an appointment made by the report requestor.	ATO rates
PIA68	General practitioners and specialists (including psychiatrists): permanent impairment assessor aircraft travel - travel by aircraft, to and from a venue for the purpose of an appointment made by the report requestor.	Economy airfare

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

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

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

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

Note 5: Economy airfare means the amount determined by ReturnToWorkSA to be the reasonable cost of undertaking the travel using a standard economy airfare.

Item No.	Description	Max Fee (excl. GST)
PERMANENT IMPAIRMENT ASSESSOR—ADDITIONAL READING TIME		
PIA29	General Practitioners: permanent impairment assessor additional reading time, payable when: - there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or - reading material is supplied in conjunction with a supplementary report request, or - a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred.	$648.50 per hour Max 2 hours
PIA79	Specialists (including psychiatrists): permanent impairment assessor additional reading time, payable when: - there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or - reading material is supplied in conjunction with a supplementary report request, or - a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred.	$648.50 per hour Max 2 hours

Note 1: Payment for the reading of written material will only be made where the reading is required for the medical practitioner to prepare a report, and where the reading is at the request or approval of a: - claims manager or self-insured employer, - worker, worker's representative or advocate.

Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in Note 1.

Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary. If greater than 500 pages remain, prior approval from ReturnToWorkSA must be sought for reading time exceeds 2-hours.

Note 4: ReturnToWorkSA expects that up to 200 pages are able to be read per hour.

Note 5: The number of pages read should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.

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

Note 7: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material.

SCHEDULE 2

Scale of Charges—Chiropractic Services

This Schedule must be read in conjunction with the Chiropractic fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
INITIAL CONSULTATIONS		
CH002	Initial consultation of not more than 30 minutes duration. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$85.50 flat fee
CH003	Initial consultation of more than 30 minutes duration. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$149.00 flat fee
SUBSEQUENT CONSULTATIONS		
CH042	Subsequent consultation of not more than 30 minutes duration. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$67.40 flat fee
CH043	Subsequent consultation of more than 30 minutes duration. Re-assessment planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the complexity of the injury, extra time is required for history taking, examination, treatment, documenting and liaison. This type of consultation is expected in only a limited number of cases for example, major trauma.	$138.80 flat fee
CHIROPRACTIC MANAGEMENT PLAN		
CHMP	Chiropractic management plan. A chiropractic management plan completed and submitted by the treating chiropractor. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the chiropractor is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 10 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$59.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
CH780	Independent clinical assessment and report. An assessment of a worker by a chiropractor, other than the treating chiropractor, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future chiropractic management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$238.20 per hour Max 4 hours

Item No.	Description	Max Fee (excl. GST)
TELEPHONE CALLS		
CH552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/ treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$33.10 flat fee
TREATING CHIROPRACTOR REPORT		
CH820	Treating chiropractor report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative. A report may be initiated by the treating chiropractor, for example when barriers have been identified that need further explanation to facilitate claims progress. When initiated by the chiropractor, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$238.20 flat fee
CASE CONFERENCE		
CH870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour
TRAVEL TIME		
CH905	Travel time. Travel by a chiropractor for the purpose of a case conference, home or hospital visit or an independent clinical assessment.	$202.20 per hour
RADIOLOGICAL SERVICES(INCLUDING INTERPRETATION BY A CHIROPRACTOR)		
CHT11	Cervical spine - 2 views	$185.00 flat fee
CHT13	Thoracic spine - 2 views	$157.10 flat fee
CHT15	Lumbo-sacral spine - 3-6 views	$216.90 flat fee
CHT16	Sacro-coccygeal area - 2 views	$130.80 flat fee
CHT27	Hip joint	$141.40 flat fee
CHT28	Pelvic girdle	$178.40 flat fee

SCHEDULE 3

Scale of Charges—Exercise Physiology Services

This Schedule must be read in conjunction with the Exercise Physiology fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
INITIAL ASSESSMENT		
EP101	Initial assessment. History, planning, education, assessment and prescription of functional exercises specific to a worker's injury, work tasks and/or work demands, in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour.	$188.90 per hour Max 1 hour
INDIVIDUAL SESSION		
EP102	Individual session. Review, planning, education, instruction, supervision and upgrade of prescribed functional and work-related exercise activities, in accordance with the Clinical Framework for the Delivery of Health Services. Maximum of 10 sessions (inclusive of initial assessment and any group sessions). Maximum 1 hour per session.	$188.90 per hour Max 1 hour
GROUP SESSION		
EP103	Group session. A session (including aquatic) during which a maximum of 8 participants are constantly and directly supervised and assessed by the exercise physiologist.	$31.40 per participant

Item No.	Description	Max Fee (excl. GST)
WORKPLACE VISIT		
EP216	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour.	$188.90 per hour Max 1 hour
EXERCISE PHYSIOLOGY MANAGEMENT PLAN		
EPMP	A ReturnToWorkSA exercise physiology management plan completed and submitted by the treating exercise physiologist. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the exercise physiologist is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 10 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.30 flat fee
TELEPHONE CALLS		
EP552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider or worker's referring/treating medical practitioner. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$26.30 flat fee
TREATING EXERCISE PHYSIOLOGY REPORT		
EP820	Treating exercise physiology report. A written clinical opinion, statement or response to questions relating to the progress and status of a worker's functional and work-related exercise activities, requested in writing by the claims manager, self-insured employer, worker or worker's representative. A report may be initiated by the treating exercise physiologist after no more than every 12th consultation or every 4 weeks (whichever is longer), for example when barriers have been identified that need further explanation to facilitate claims progress, or when surgery has been requested and further information could assist the assessment process. When initiated by the exercise physiologist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$188.90 flat fee
CASE CONFERENCE		
EP870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*.	$188.90 per hour
TRAVEL TIME		
EP905	Travel time. Travel by an exercise physiologist for the purpose of a case conference, home, hospital or workplace visit.	$160.40 per hour
TELEHEALTH INITIAL ASSESSMENT		
EPTE9	Telehealth/telephone initial assessment. History, planning, education, assessment and prescription of functional exercises specific to a worker s injury, work tasks and/or work demands, in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour. Where possible, video consultations are preferred. Exercise Physiologists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible.	$188.90 per hour Max 1 hour
TELEHEALTH INDIVIDUAL SESSION		
EPTE2	Telehealth/telephone individual session. Review, planning, education, instruction, supervision and upgrade of prescribed functional and work-related exercise activities. Maximum of 10 sessions, up to a maximum of 1 hour per session.	$188.90 per hour Max 1 hour

SCHEDULE 4

Scale of Charges—Occupational Therapy Services

This Schedule must be read in conjunction with the Occupational Therapy fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
OT105	Initial consultation. History, assessment planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$238.20 per hour
OT205	Subsequent consultation. Re-assessment planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$238.20 per hour
OCCUPATIONAL THERAPY MANAGEMENT PLAN		
OTMP	Occupational therapy management plan. An occupational therapy management plan completed and submitted by the treating occupational therapist. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the occupational therapist is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 10 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$59.70 flat fee
WORKPLACE VISIT		
OT216	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/ employer should also be present to facilitate a team approach. Maximum 1 hour.	$238.20 per hour Max 1 hour
CORRECTIVE/SERIAL SPLINTING		
OT300	Fabrication/fitting/adjustment of splint	$238.20 per hour
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
OT780	Independent clinical assessment and report. An assessment of a worker by an occupational therapist, other than the treating occupational therapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future occupational therapy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$238.20 per hour Max 4 hours
ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT		
OT760	Activities of daily living assessment and report. Assessment of a worker's level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours.	$238.20 per hour Max 5 hours
ACTIVITIES OF DAILY LIVING RE-ASSESSMENT		
OT762	Activities of daily living: implementation and review. Re-assessment and review of a worker's progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours.	$238.20 per hour Max 2 hours
DRIVER ASSESSMENT, REHABILITATION AND REPORT		
OTDVA	Driver assessment and report. Assessment of the impact of a worker's injury/condition on their ability to return to safe and independent driving and where appropriate, develop a driver rehabilitation plan. This service must be requested in writing by the claims manager, self-insured employer or treating medical practitioner. Maximum 5 hours.	$238.20 per hour Max 5 hours
OTDVR	Driver rehabilitation and report. Implementation of a driver rehabilitation plan. This service must be requested in writing by the claims manager, self-insured employer or treating medical practitioner.	$238.20 per hour

Item No.	Description	Max Fee (excl. GST)
TELEPHONE CALLS		
OT552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/ treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report, activities of daily living assessment and report, an activities of daily living re-assessment or driver assessment/rehabilitation and report, is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$33.10 flat fee
TREATING OCCUPATIONAL THERAPY REPORT		
OT820	Treating occupational therapist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative. A report may be initiated by the treating occupational therapist, for example when barriers have been identified that need further explanation to facilitate claims progress, or when surgery has been requested and further information could assist the assessment process. When initiated by the occupational therapist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$238.20 flat fee
CASE CONFERENCE		
OT870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour
TRAVEL TIME		
OT905	Travel time. Travel by an occupational therapist for the purpose of a case conference, home, hospital or worksite visit, independent clinical or activities of daily living assessment.	$202.20 per hour
TELEHEALTH INITIAL CONSULTATION		
OTTE0	Telehealth/telephone initial consultation. History, assessment, planning and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour. Where possible, video consultations are preferred. Occupational Therapists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible.	$238.20 per hour Max 1 hour
TELEHEALTH SUBSEQUENT CONSULTATION		
OTTE2	Telehealth/telephone subsequent consultation. Review, planning, education, and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 10 sessions. Occupational Therapists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible.	$238.20 per hour

SCHEDULE 5

Scale of Charges—Osteopathy Services

This Schedule must be read in conjunction with the Osteopathy fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
OS200	Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$156.80 flat fee
OS220	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$115.70 flat fee
OSTEOPATHY MANAGEMENT PLAN		
OSMP	Osteopathy management plan. An osteopathy management plan completed and submitted by the treating osteopath. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the osteopath is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 10 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$59.70 flat fee

Item No.	Description	Max Fee (excl. GST)
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
OS780	Independent clinical assessment and report. An assessment of a worker by an osteopath, other than the treating osteopath, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future osteopathy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$238.20 per hour Max 4 hours
TELEPHONE CALLS		
OS552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, a claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/ treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$33.10 flat fee
TREATING OSTEOPATH REPORT		
OS820	Treating osteopath report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative. A report may be initiated by the treating osteopath, for example when barriers have been identified that need further explanation to facilitate claims progress, or when surgery has been requested and further information could assist the assessment process. When initiated by the osteopath, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$238.20 flat fee
CASE CONFERENCE		
OS870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour
TRAVEL TIME		
OS905	Travel time. Travel by an osteopath for the purpose of a case conference, home or hospital visit or an independent clinical assessment.	$202.20 per hour
RADIOLOGICAL SERVICES(INCLUDING INTERPRETATION BY AN OSTEOPATH)		
OST11	Cervical spine - 2 views	$185.00 flat fee
OST13	Thoracic spine - 2 views	$157.10 flat fee
OST15	Lumbo-sacral spine 3 - 6 views	$216.90 flat fee
OST16	Sacro-coccygeal area - 2 views	$130.80 flat fee
OST27	Hip joint	$141.40 flat fee
OST28	Pelvic girdle	$178.40 flat fee

SCHEDULE 6

Scale of Charges—Physiotherapy Services

This Schedule must be read in conjunction with the Physiotherapy fee Schedule and policy

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
PT108	Initial consultation. History, assessment, planning education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$119.20 flat fee
PT210	Subsequent consultation. Re-assessment, planning education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$99.30 flat fee
PT212	Long subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the complexity of the presentation, extra time is required for history taking, examination, treatment, documenting and liaison. This type of consultation is expected in only a limited number of cases for example, the requirement of an interpreter, injuries following extensive burns, major trauma and major surgery requiring intensive post-operative treatment.	$119.30 flat fee

Item No.	Description	Max Fee (excl. GST)
RESTRICTED CONSULTATION		
PT214	Restricted consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the nature of the injury, extra time (up to one hour) is required for history taking, examination, treatment, documenting and liaison. A restricted consultation can only be requested by the treating physiotherapist where a prior consultation has been delivered, or -titled/specialist physiotherapists in the disciplines of pain, neurology, pelvic/continence or hand therapists (regardless of whether a prior consultation has been delivered) Up to 6 sessions may be requested per application and approval is granted by the claims manager on a case-by-case basis. Maximum 1 hour.	$238.20 per hour Max 1 hour
WORKPLACE VISIT		
PT216	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purposes of determining ongoing treatment needs and where appropriate, review movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour.	$238.20 per hour Max 1 hour
CORRECTIVE/SERIAL SPLINTING		
PT300	Fabrication/fitting/adjustment of a splint.	$238.20 per hour
PT390	Materials used to construct or modify a splint.	Reasonable cost
INDIVIDUAL AQUATIC SESSION		
PT415	Individual aquatic session. A session during which an individual worker is constantly and directly supervised and assessed by the physiotherapist. Maximum 4 sessions.	$83.50 flat fee
GROUP AQUATIC SESSION		
PT420	Group aquatic session. A session during which a maximum of six participants are constantly and directly supervised and assessed by the physiotherapist.	$37.40 per worker
INDIVIDUAL EXERCISE SESSION		
PT455	Individual exercise session. A session during which an individual worker is constantly and directly supervised and assessed by the physiotherapist. Maximum 4 sessions.	$83.50 flat fee
GROUP EXERCISE		
PT460	Group exercise session. A session during which a maximum of six participants are constantly and directly supervised and assessed by the physiotherapist.	$37.40 per worker
ENTRY FEE, AQUATIC OR EXERCISE FACILITY		
PT429	Entry fee to an aquatic or exercise facility. Reimbursement to the physiotherapist for an entry fee paid to the aquatic or exercise facility by the physiotherapist, on behalf of a worker. Where a physiotherapist is employed by the facility, item PT429 cannot be charged.	Reasonable cost
PHYSIOTHERAPY MANAGEMENT PLAN		
PTMP	A physiotherapy management plan completed and submitted by the treating physiotherapist. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the physiotherapist is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 10 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$59.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
PT780	Independent clinical assessment and report. An assessment of a worker, by a physiotherapist, other than the treating physiotherapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future physiotherapy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$238.20 per hour Max 4 hours
ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT		
PT760	Activities of daily living assessment and report. Assessment of a worker's level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours.	$238.20 per hour Max 5 hours

Item No.	Description	Max Fee (excl. GST)
ACTIVITIES OF DAILY LIVING RE-ASSESSMENT		
PT762	Activities of daily living: Implementation and review. Re-assessment and review of a worker's progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours.	$238.20 per hour Max 2 hours
TELEPHONE CALLS		
PT552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/ treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report, activities of daily living assessment and report or an activities of daily living re-assessment, is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$33.10 flat fee
TREATING PHYSIOTHERAPY REPORT		
PT820	Treating physiotherapist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative. A report may be initiated by the treating physiotherapist for example, when barriers have been identified that need further explanation to facilitate claims progress, or when surgery has been requested and further information could assist the assessment process. When initiated by the physiotherapist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$238.20 flat fee
CASE CONFERENCE		
PT870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour
TRAVEL TIME		
PT905	Travel time. Travel by a physiotherapist for the purpose of a case conference, home, hospital or worksite visit, independent clinical or activities of daily living assessment.	$202.20 per hour
TRAVEL EXPENSES		
PT907	Travel expenses. Travel expenses incurred for a medical service delivered at the request of the claims manager or self-insured employer, where the provider is required to travel to a destination greater than 100km from the provider's principal place of business or residential address. Car hire can only be charged where the provider travels by aircraft to deliver the service.	Reasonable cost
TELEHEALTH INITIAL CONSULTATION		
PTTE9	Telehealth/Telephone initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Where possible, video consultations are preferred. Physiotherapists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible.	$119.20 flat fee
TELEHEALTH SUBSEQUENT CONSULTATION		
PTTE0	Telehealth/telephone subsequent consultation. Review, planning, education, and exercise prescription/monitoring. Maximum 10 sessions.	$99.30 flat fee
TELEHEALTH LONG SUBSEQUENT CONSULTATION		
PTTE2	Telehealth/telephone long subsequent consultation. Review, planning, education, and exercise prescription/monitoring. This type of consultation is expected in only a limited number of cases where longer physiotherapy treatment is required, for example to engage an interpreter or for education purposes. Maximum 10 sessions.	$119.30 flat fee
TELEHEALTH RESTRICTED CONSULTATION		
PTTE4	Telehealth/telephone restricted consultation. Review, planning, education, and exercise prescription/monitoring. This type of consultation is expected in only a limited number of cases where longer physiotherapy treatment is required, for example to engage an interpreter or for education purposes. Prior approval from the claims manager is required. Maximum 10 sessions up to a maximum of 1 hour per session.	$238.20 per hour Max 1 hour

SCHEDULE 7

Scale of Charges—Psychology Services

This Schedule must be read in conjunction with the Psychology fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
PS200	Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$265.20 per hour Max 1.5 hours
PS220	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$265.20 per hour Max 1.5 hours
PSYCHOLOGICAL ASSESSMENT		
PS230	Psychological assessment. Clinical or psychometric assessment and interpretation of results. Maximum 2 hours.	$265.20 per hour Max 2 hours
NEUROPSYCHOLOGICAL ASSESSMENT AND REPORT		
PS232	Neuropsychological assessment and report. Neuropsychological assessment of a worker and provision of a report by a clinical neuropsychologist. This service must be requested in writing by the claims manager or self-insured employer. Maximum 12 hours.	$265.20 per hour
CONSULTATION WITH ANOTHER PERSON(S) OTHER THAN A WORKER		
PS240	Interview with a person (s) other than a worker. Interview with a person (s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker's injury. Maximum 1.5 hours.	$265.20 per hour Max 1.5 hours
GROUP THERAPY		
PS250	Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a psychologist. 'Group' means attendance by a minimum of 2 persons and maximum of 15 persons.	$52.50 per participant
WORKPLACE VISIT		
PS256	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour.	$265.20 per hour Max 1 hour
PSYCHOLOGY MANAGEMENT PLAN		
PSMP	Psychology management plan. A psychology management plan completed and submitted by the treating psychologist. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the psychologist is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 6 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$66.40 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
PS780	Independent clinical assessment and report. An assessment of a worker by a psychologist, other than the treating psychologist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future psychology and/or mental health management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$265.20 per hour
TELEPHONE CALLS		
PS552	Telephone calls. Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. Maximum 0.5 hours. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$265.20 per hour Max. 0.5 hours

Item No.	Description	Max Fee (excl. GST)
TREATING PSYCHOLOGY REPORTS		
PS810	Treating psychologist comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker s representative. Maximum 4 hours.	$265.20 per hour Max 4 hours
PS820	Treating psychologist summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker's representative or initiated by the psychologist after every 6th consultation. When initiated by the psychologist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$265.20 flat fee
CASE CONFERENCE		
PS870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$265.20 per hour
TRAVEL TIME		
PS905	Travel time. Travel by a psychologist for the purpose of a case conference, home or hospital visit or an independent clinical assessment.	$225.10 per hour

SCHEDULE 8

Scale of Charges—Speech Pathology Services

This Schedule must be read in conjunction with the Speech pathology fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
INITIAL CONSULTATION		
E0300	Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 2.5 hours.	$238.20 per hour
SUBSEQUENT CONSULTATION		
E0320	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour.	$238.20 per hour Max 1 hour
SPEECH PATHOLOGY MANAGEMENT PLAN		
E0MP	Speech pathology management plan. A speech pathology management plan completed and submitted by the treating speech pathologist. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the speech pathologist is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 10 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$59.70 flat fee
TELEPHONE CALLS		
E0552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/ treating medical practitioner. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$33.10 flat fee

Item No.	Description	Max Fee (excl. GST)
TREATING SPEECH PATHOLOGY REPORT		
E0820	Treating speech pathologist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative. A report may be initiated by the treating speech pathologist for example, when barriers have been identified that need further explanation to facilitate claims progress, or when surgery has been requested and further information could assist the assessment process. When initiated by the speech pathologist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$357.40 flat fee
CASE CONFERENCE		
E0870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour
TRAVEL TIME		
E0905	Travel time. Travel by a speech pathologist for the purpose of case conference, home or hospital visit.	$202.20 per hour

SCHEDULE 9

Scale of Charges—Audiology Services

This Schedule must be read in conjunction with the Audiology fee Schedule and policy.

Item No.	Description	Max Fee (excl. GST)
ASSESSMENT		
AU101	Assessment: An assessment determines the worker's hearing requirements and independence level as a result of their work injury. This includes obtaining a clinical history, diagnostic testing including appropriately masked air and bone conduction audiometry, collaborative rehabilitative goal setting, reasonable cost effective recommendations, clinical justification and a brief written summary to the claims manager inclusive of the above. The Audiologist/Audiometrist must refer the worker to another clinician if the patient presents with issues outside of their scope of practice. To be billed on a pro rata basis rounded to the nearest 6 minutes. Max. 1 hour	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 1 hour
MONAURAL FITTING AND FOLLOW-UP		
AU102	Monaural Fitting: For the supply and fitting of the hearing aid, instructions around appropriate use of the hearing aid, use of relevant outcome measures (such as the Client Oriented Scale of Improvement as an example), and 1 year supply of batteries (where applicable). Hearing aid specifications and details (serial numbers and device codes, copy of the consumer warranty), details of adjustments or modifications to achieve optimal fit, and completed outcome measures must be provided to the claims manager. This fee cannot be charged where there is a device replacement within 12 months of the initial fitting.	$289.70 flat fee
AU106	Monaural Follow Up: Follow-up reviews and appropriate fine tuning and education to ensure optimal outcomes for 1 year after audiological intervention, Each service to be billed on a pro rata basis rounded to the nearest 6 minutes.	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 2.5 hours
BINAURAL FITTING AND FOLLOW-UP		
AU103	Binaural Fitting: For the supply and fitting of the hearing aid, instructions around appropriate use of the hearing aid, use of relevant outcome measures (such as the Client Oriented Scale of Improvement as an example), and 1 year supply of batteries (where applicable). Binaural Hearing fitting will only be provided for demonstrated compensable hearing loss in both ears. Hearing aid specifications and details (serial numbers and device codes, copy of the consumer warranty), details of adjustments or modifications to achieve optimal fit, and completed outcome measures must be provided to the claims manager. This fee cannot be charged where there is a device replacement within 12 months of the initial fitting.	$467.30 flat fee
AU107	Binaural Follow Up: Follow-up reviews and appropriate fine tuning and education to ensure optimal outcomes for 1 year after audiological intervention. Each service to be billed on a pro rata basis rounded to the nearest 6 minutes.	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 3.5 hours

Item No.	Description	Max Fee (excl. GST)
HEARING AID		
AU201	Hearing Aid: The worker is assigned the appropriate hearing aid depending upon the clinical need determined through audiogram findings, lifestyle and dexterity of the worker, with sufficient capacity to modify/adjust to foreseeable changes in hearing needs within 5 years. The fee shall be the provider specific wholesale price of hearing aid + 5% mark-up to the maximum specified in the fee schedule.	$2,020.00 maximum
AU206	Rechargeable Hearing Aid: The worker is assigned the appropriate hearing aid depending upon the clinical need determined through audiogram findings, lifestyle and dexterity of the worker, with sufficient capacity to modify/adjust to foreseeable changes in hearing needs within 5 years. The fee shall be the provider specific wholesale price of hearing aid + 5% mark-up to the maximum specified in the fee schedule.	$2,020.00 maximum
REHABILITATION AND ADJUSTMENT		
AU104	Rehabilitation and adjustment: The monaural or binaural follow up fees cover rehabilitation and adjustment for 1 year following the initial fitting. Following this period, audiological services may be provided for hearing aid adjustment or rehabilitation to ensure optimal recovery and transition following the previous intervention. Only applicable from 12 months after the fitting of a hearing device for a maximum of up to 6 hours of service during the life of the hearing aid, a brief summary of rehabilitation/adjustment to be provided to the claims manager and each service to be rounded to the nearest 6 minutes.	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 6 hours
HEARING AID REPAIRS		
AU203	Hearing aid repairs: The claims manager will only consider payments for the repair and maintenance of hearing aids/devices as a result of normal wear and tear, that are not covered by the manufacturer or supplier warranty and following receipt of the request for repair or a replacement device form, proof of consumer warranty, and either: - the manufacturer's quote for the repairs that details the damaged components and the cost to repair the device or damaged component, OR - the manufacturer's fixed cost for repair/replacement.	Reasonable cost
BATTERIES		
AU204	Batteries: The monaural or binaural fitting fees include a one-year supply of batteries. Only applicable 12 months after the fitting of a hearing device. Fee is per hearing device/year.	$101.00 maximum
REPORT		
AU105	Standard report: A standard report can only be requested by the claims manager, and should be provided within 10 days of the request. The report should be based on the provider's notes/ assessments carried out and would not usually require consultation with the patient.	$248.10 flat fee
TELEHEALTH MONAURAL FITTING AND FOLLOW-UP		
AUTE2	Telehealth Monaural supply and fitting of the hearing aid. This fee is inclusive of supply and fitting of a like-for-like, pre-programmed, hearing aid when: the existing device has been lost or damaged and is not covered by warranty or insurance, or 5 years has elapsed and the workers hearing needs have not changed. Includes 1 years' supply of batteries. If a like-for-like device cannot be provided or is not suitable, this fee item cannot be charged and telehealth is not suitable. Claims manager approval is required prior to conducting telehealth services. Hearing aid specifications and details (serial numbers and device codes, copy of the consumer warranty), details of adjustments or modifications to achieve optimal fit, and completed outcome measures must be provided to the claims manager. This fee cannot be charged where there is a device replacement within 12 months of the initial fitting.	$289.70 flat fee
AUTE6	Telehealth Monaural Follow Up: Follow-up reviews and appropriate fine tuning and education to ensure optimal outcomes for 1 year after audiological intervention. Each service to be billed on a pro rata basis rounded to the nearest 6 minutes.	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 2.5 hours
TELEHEALTH BINAURAL FITTING AND FOLLOW-UP		
AUTE3	Telehealth Binaural supply and fitting of the hearing aids. This fee is inclusive of supply and fitting of a like-for-like, pre-programmed, hearing aid when: the existing device has been lost or damaged and is not covered by warranty or insurance, or 5 years has elapsed and the workers hearing needs have not changed. Includes 1 years' supply of batteries. If a like-for-like device cannot be provided or is not suitable, this fee item cannot be charged and telehealth is not suitable. Claims manager approval is required prior to conducting telehealth services. Hearing aid specifications and details (serial numbers and device codes, copy of the consumer warranty), details of adjustments or modifications to achieve optimal fit, and completed outcome measures must be provided to the claims manager. This fee cannot be charged where there is a device replacement within 12 months of the initial fitting.	$467.30 flat fee

Item No.	Description	Max Fee (excl. GST)
AUTE7	Telehealth Binaural Follow Up: Follow-up reviews and appropriate fine tuning and education to ensure optimal outcomes for 1 year after audiological intervention. Each service to be billed on a pro rata basis rounded to the nearest 6 minutes.	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 3.5 hours
TELEHEALTH REHABILITATION AND ADJUSTMENT		
AUTE4	Telehealth rehabilitation and adjustment: The telehealth monaural or binaural follow up fees cover rehabilitation and adjustment for 1 year following the initial fitting. Following this period, telehealth audiological services may be provided for hearing aid adjustment or rehabilitation to ensure optimal recovery and transition following the previous intervention. Claims manager approval is required prior to conducting telehealth services. Only applicable from 12 months after the fitting of a hearing device for a maximum of up to 6 hours of service during the life of the hearing aid, a brief summary of rehabilitation/adjustment to be provided to the case manager and each service to be rounded to the nearest 6 minutes.	Audiologist: $248.10 per hour Audiometrist: $222.70 per hour Max 6 hours

SCHEDULE 10

Scale of Charges—Accredited Mental Health Social Work Services

This Schedule must be read in conjunction with the Accredited Mental health social worker fee Schedule and guidelines.

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
MHSW01	Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$188.90 per hour Max 1.5 hours
MHSW02	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$188.90 per hour Max 1.5 hours
STANDARDISED ASSESSMENT		
MHSW04	Standardised assessment. Standardised clinical or psychometric assessment and interpretation of results. Maximum 2 hours.	$188.90 per hour Max 2 hours
INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER		
MHSW10	Interview with a person (s) other than a worker. Interview with a person (s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker's injury. Maximum 1.5 hours.	$188.90 per hour Max 1.5 hours
GROUP THERAPY		
MHSW20	Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of an accredited mental health social worker. 'Group' means attendance by a minimum of 2 persons and maximum of 15 persons.	$37.80 per participant
WORKPLACE VISIT		
MHSW26	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour.	$188.90 per hour Max 1 hour
MENTAL HEALTH MANAGEMENT PLAN		
MHSWMP	Mental health management plan. A mental health management plan completed and submitted by the treating accredited mental health social worker. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the AMHSW is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 6 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.30 flat fee
TELEPHONE CALLS		
MHSW52	Telephone calls. Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Maximum 0.5 hours. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$188.90 per hour Max 0.5 hours

Item No.	Description	Max Fee (excl. GST)
TREATING ACCREDITED MENTAL HEALTH SOCIAL WORKER REPORTS		
MHSW60	Treating accredited mental health social work summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker's representative or initiated by the accredited mental health social worker after every 6th consultation. When initiated by the accredited mental health social worker, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$188.90 flat fee
MHSW62	Treating accredited mental health social work comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 2 hours.	$188.90 per hour Max 2 hours
CASE CONFERENCE		
MHSW70	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$188.90 per hour
TRAVEL TIME		
MHSW90	Travel time. Travel by an accredited mental health social worker for the purpose of a case conference, home, hospital or workplace visit.	$160.40 per hour

SCHEDULE 11

Scale of Charges-Counsellor Services

This Schedule must be read in conjunction with the Counselling fee Schedule and guidelines.

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
MHC01	Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$188.90 per hour 1.5 hours
MHC02	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$188.90 per hour Max 1.5 hours
INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER		
MHC10	Interview with a person (s) other than a worker. Interview with a person (s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker's injury. Maximum 1.5 hours.	$188.90 per hour Max 1.5 hours
GROUP THERAPY		
MHC20	Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a counsellor. 'Group' means attendance by a minimum of 2 persons and maximum of 15 persons.	$37.80 per participant
WORKPLACE VISIT		
MHC26	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour.	$188.90 per hour Max 1 hour
MENTAL HEALTH MANAGEMENT PLAN		
MHCMP	Mental health management plan. A mental health management plan completed and submitted by the treating counsellor. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the counsellor is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 6 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.30 flat fee

Item No.	Description	Max Fee (excl. GST)
TELEPHONE CALLS		
MHC52	Telephone calls. Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Maximum 0.5 hours. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$188.90 per hour Max 0.5 hours
TREATING COUNSELLOR REPORTS		
MHC60	Treating counsellor summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker's representative or initiated by the counsellor after every 6th consultation. When initiated by the counsellor, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$188.90 flat fee
MHC62	Treating counsellor comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 2 hours.	$188.90 per hour Max 2 hours
CASE CONFERENCE		
MHC70	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$188.90 per hour
TRAVEL TIME		
MHC90	Travel time. Travel by a counsellor for the purpose of a case conference, home, hospital or workplace visit.	$160.40 per hour

SCHEDULE 12

Scale of Charges-Mental Health Occupational Therapy Services

This Schedule must be read in conjunction with the Mental health occupational therapy fee Schedule and guidelines.

Item No.	Description	Max Fee (excl. GST)
CONSULTATIONS		
MHOT01	Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$238.20 per hour Max 1.5 hours
MHOT02	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$238.20 per hour Max 1.5 hours
STANDARDISED ASSESSMENT		
MHOT04	Standardised assessment. Standardised clinical or psychometric assessment and interpretation of results. Maximum 2 hours.	$238.20 per hour Max 2 hours
INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER		
MHOT10	Interview with a person (s) other than a worker. Interview with a person (s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker's injury. Maximum 1.5 hours.	$238.20 per hour Max 1.5 hours
GROUP THERAPY		
MHOT20	Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a mental health occupational therapist. 'Group' means attendance by a minimum of 2 persons and maximum of 15 persons.	$47.20 per participant
WORKPLACE VISIT		
MHOT26	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour.	$238.20 per hour Max 1 hour

Item No.	Description	Max Fee (excl. GST)
MENTAL HEALTH MANAGEMENT PLAN		
MHMP	Mental health management plan. A mental health management plan completed and submitted by the treating mental health occupational therapist. This plan is available on our website at www.rtwsa.com. For claims managed by ReturnToWorkSA or their claims agents, the mental health occupational therapist is expected to submit a plan at the request of the claims manager. The practitioner can initiate a management plan after every 6 treatments where it supports and facilitates treatment review and discussion with the worker and/or the treatment team. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$59.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
MHOT30	Independent clinical assessment and report. An assessment of a worker by a mental health occupational therapist, other than the treating mental health occupational therapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future mental health management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$238.20 per hour Max 4 hours
ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT		
MHOT40	Activities of daily living assessment and report. Assessment of a worker's level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours.	$238.20 per hour Max 5 hours
ACTIVITIES OF DAILY LIVING IMPLEMENTATION AND REPORT		
MHOT42	Activities of daily living: implementation and review. Re-assessment and review of a worker's progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours.	$238.20 per hour Max 2 hours
TELEPHONE CALLS		
MHOT52	Telephone calls. Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. Maximum 0.5 hours. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour Max 0.5 hours
TREATING MENTAL HEALTH OCCUPATIONAL THERAPY REPORTS		
MHOT60	Treating mental health occupational therapist summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker's representative or initiated by the treating mental health occupational therapist after every 6th consultation. When initiated by the mental health occupational therapist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties.	$238.20 flat fee
MHC62	Treating mental health occupational therapist comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$238.20 per hour Max 4 hours
CASE CONFERENCE		
MHOT70	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$238.20 per hour
TRAVEL TIME		
MHOT90	Travel time. Travel by a mental health occupational therapist for the purpose of a case conference, home, hospital or workplace visit, independent clinical or activities of daily living assessment or re-assessment.	$202.20 per hour

SCHEDULE 13

Scale of Charges—Private Hospital and Day Surgery Facility Services

This Schedule must be read in conjunction with the Private hospital fee Schedule and guidelines.

PART 1—PRELIMINARY

1. Interpretations

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

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

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

AR-DRG means Australian Refined Diagnosis Related Group.

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

day means a calendar day.

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

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

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

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

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

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

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

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

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

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

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

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

(3) For the purposes of this Schedule—–

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

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

(4) For the purposes of this Schedule—–

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

(i) accommodation;

(ii) intensive care unit;

(iii) theatre;

(iv) common use theatre items;

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

(vi) television;

(vii) newspapers;

(viii) local telephone calls;

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

(x) consumable items.

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

(i) the cost of prostheses;

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

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

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

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

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

(vii) transfer costs;

(viii) boarder fees.

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

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

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

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

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

PART 2—PRIVATE HOSPITAL SERVICES

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

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

3. Other private hospital services

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

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

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

Maximum Charge = Rate per day × 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 × (LOS – Upper trim point))

where—

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

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

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

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

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

PART 3—DAY SURGERY FACILITY SERVICES

4. Day Surgery Facility Services

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

PART 4—TABLES

Table 1

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

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

Item No.	Description	Max Fee (excl. GST)
HOSPITAL REHABILITATION SERVICES		
	Rehabilitation Orthopaedic Program for Inpatients	
	Orthopaedic programs involve referral and assessment by the rehabilitation coordinator of the program. It is a defined program with intense service provision. Rapid improvement is expected and there are specific outcome goals. The program includes physiotherapy, aquatic therapy, occupational therapy, case conferences and discharge planning.	
PR600	Rehabilitation orthopaedic program: 1 or more days but not more than 16 days	$940.40 per day
PR605	Rehabilitation orthopaedic program: 17 or more days	$788.60 per day
	Rehabilitation Trauma Program for Inpatients	
	Trauma programs involve referral and assessment by the rehabilitation coordinator of the program. It is a defined program with intense service provision. Rapid improvement is expected and there are specific outcome goals. The program includes physiotherapy, aquatic therapy, occupational therapy, speech therapy, case conferences and discharge planning.	
PR610	Rehabilitation trauma program: 1 or more days but not more than 20 days	$1,121.40 per day
PR615	Rehabilitation trauma program: 21 or more days	$1,012.40 per day

Item No.	Description	Max Fee (excl. GST)
PSYCHIATRIC SERVICES		
	Inpatient Services	
PR800	Psych inpatient: 1 or more days but not more than 14 days	$902.30 per day
PR803	Psych inpatient: 15 or more days	$694.40 per day
PR822	Psych inpatient: Electro-convulsive therapy (ECT)	$386.10 per day
PR850	Psych inpatient private room allocated on the basis of clinical need	Extra $22.50 per day
	Drug and Alcohol Programs—Inpatient	
	This program provides specialised treatment and care for patients with alcohol or drug dependencies (including analgesics/narcotics/ opiates and Benzodiazepine). The program is managed by a multi-disciplinary team including a medical director and consultant psychiatrists. Where required, the program involves a medically controlled, safe withdrawal of drugs or alcohol.	
PR990	Drug and alcohol program—inpatient, 1 or more days but not more than 10 days	$1,022.90 per day
PR991	Drug and alcohol program—inpatient, 11 or more days	$748.70 per day
	Same-day Psychiatric Services	
	A day program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients. It is managed by a multi-disciplinary team of health care professionals, and is tailored to the individual needs of the patient. It can include specialised therapy modules including cognitive behavioural therapy, relaxation, assertiveness skills and anxiety management.	
	Outreach is treatment or care provided by the hospital to a non-admitted patient at a location outside the hospital premises (being treatment or care provided as a direct substitute for treatment or care that would normally be provided on the hospital premises).	
	Please note, for billing purposes, the O in item numbers for same day services is an alphabetical letter not the number zero.	
PRO81	Psych same day group session	$123.00
PRO82	Psych same day ECT day program	$641.30
PRO83	Psych same day half-day program	$328.40
PRO84	Psych same day—day program	$519.60
PRO95	Psych same day outreach	$296.60
OTHER SERVICES		
	Inpatient Pain Assessment/Management	
PR700	Inpatient pain assess/mgmt: 1 or more days but not more than 7 days	$825.30 per day
PR705	Inpatient pain assess/mgmt: 8 or more days but not more than 14 days	$775.40 per day
PR710	Inpatient pain assess/mgmt: 15 or more days	$504.00 per day
	Pain Pumps for Non-admitted Patients	
PR720	Implanted infusion pump, refilling of reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain for a non-admitted patient.	$286.50

OTHER SERVICES

Table 2

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

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

Inpatient Services—Diagnostic Related Groups Version 8.0

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
801A	OR Procedures Unrelated to Principal Diagnosis, Major Complexity	$28,831.60	35	8	$1,106.10
801B	OR Procedures Unrelated to Principal Diagnosis, Intermediate Complexity	$10,152.50	13	2	$1,368.90
801C	OR Procedures Unrelated to Principal Diagnosis, Minor Complexity	$4,323.50	5	0	$1,446.20
960Z	Ungroupable	$2,108.40	11	2	$321.20
961Z	Unacceptable Principal Diagnosis	$1,397.30	4	0	$632.10
A06A	Tracheostomy and/or Ventilation >=96hours, Major Complexity	$148,402.30	35	19	$1,446.20
A06B	Tracheostomy and/or Ventilation >=96hours, Intermediate Complexity	$92,409.40	35	11	$1,446.20
A06C	Tracheostomy and/or Ventilation >=96hours, Minor Complexity	$61,122.40	35	6	$1,446.20
A08A	Autologous Bone Marrow Transplant, Major Complexity	$33,756.80	35	8	$1,377.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
A08B	Autologous Bone Marrow Transplant, Minor Complexity	$9,871.00	15	2	$1,230.50
A11A	Insertion of Implantable Spinal Infusion Device, Major Complexity	$14,756.30	23	4	$1,252.00
A11B	Insertion of Implantable Spinal Infusion Device, Minor Complexity	$7,739.80	10	2	$1,446.20
A12Z	Insertion of Neurostimulator Device	$5,872.60	5	0	$1,446.20
A40B	ECMO, Minor Complexity	$38,305.10	21	3	$1,446.20
B01A	Ventricular Shunt Revision, Major Complexity	$16,772.90	29	5	$1,050.00
B01B	Ventricular Shunt Revision, Minor Complexity	$8,870.60	8	1	$1,446.20
B02A	Cranial Procedures, Major Complexity	$39,158.80	35	8	$1,446.20
B02B	Cranial Procedures, Intermediate Complexity	$22,165.00	20	3	$1,446.20
B02C	Cranial Procedures, Minor Complexity	$16,123.50	12	2	$1,446.20
B03A	Spinal Procedures, Major Complexity	$19,105.10	21	3	$1,446.20
B03B	Spinal Procedures, Intermediate Complexity	$11,036.00	8	1	$1,446.20
B03C	Spinal Procedures, Minor Complexity	$8,733.30	6	0	$1,446.20
B04A	Extracranial Vascular Procedures, Major Complexity	$22,774.30	35	6	$1,232.30
B04B	Extracranial Vascular Procedures, Intermediate Complexity	$14,754.70	13	2	$1,446.20
B04C	Extracranial Vascular Procedures, Minor Complexity	$10,013.20	7	1	$1,446.20
B05Z	Carpal Tunnel Release	$1,599.10	4	0	$1,126.70
B06A	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Major Comp	$14,103.60	22	4	$1,091.70
B06B	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Interm Comp	$5,825.70	8	1	$1,196.70
B06C	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Minor Comp	$2,573.40	4	0	$1,436.00
B07A	Cranial or Peripheral Nerve and Other Nervous System Procedures, Major Comp	$13,513.80	26	4	$957.70
B07B	Cranial or Peripheral Nerve and Other Nervous System Procedures, Minor Comp	$3,320.70	4	0	$1,446.20
B40Z	Plasmapheresis W Neurological Disease, Sameday	$690.60	1	1	N/A
B41Z	Telemetric EEG Monitoring	$3,995.60	8	1	$1,114.20
B42A	Nervous System Disorders W Ventilator Support, Major Complexity	$34,194.20	35	8	$1,446.20
B60A	Acute Paraplegia and Quadriplegia W or W/O OR Procedures, Major Complexity	$13,809.00	28	5	$963.40
B60B	Acute Paraplegia and Quadriplegia W or W/O OR Procedures, Minor Complexity	$6,117.70	12	2	$1,008.90
B61A	Spinal Cord Conditions W or W/O OR Procedures, Major Complexity	$11,272.80	19	3	$1,089.70
B61B	Spinal Cord Conditions W or W/O OR Procedures, Minor Complexity	$4,166.60	6	0	$1,101.50
B63A	Dementia and Other Chronic Disturbances of Cerebral Function, Major Complexity	$10,476.00	27	4	$777.80
B63B	Dementia and Other Chronic Disturbances of Cerebral Function, Minor Complexity	$4,365.10	12	2	$738.20
B64A	Delirium, Major Complexity	$8,454.50	20	3	$845.30
B64B	Delirium, Minor Complexity	$4,505.20	10	2	$955.50
B65A	Cerebral Palsy, Major Complexity	$1,388.10	7	1	$441.20
B65B	Cerebral Palsy, Minor Complexity	$1,363.10	4	0	$677.10
B66A	Nervous System Neoplasms, Major Complexity	$8,661.00	22	4	$803.30
B66B	Nervous System Neoplasms, Minor Complexity	$3,295.60	9	1	$756.50

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
B67A	Degenerative Nervous System Disorders, Major Complexity	$5,441.00	14	2	$808.40
B67B	Degenerative Nervous System Disorders, Intermediate Complexity	$911.10	4	0	$543.70
B67C	Degenerative Nervous System Disorders, Minor Complexity	$681.00	4	0	$624.20
B68A	Multiple Sclerosis and Cerebellar Ataxia, Major Complexity	$3,032.50	8	1	$845.30
B68B	Multiple Sclerosis and Cerebellar Ataxia, Minor Complexity	$671.50	4	0	$588.10
B69A	TIA and Precerebral Occlusion, Major Complexity	$6,554.60	15	2	$894.90
B69B	TIA and Precerebral Occlusion, Minor Complexity	$2,594.20	6	0	$967.40
B70A	Stroke and Other Cerebrovascular Disorders, Major Complexity	$23,045.80	35	9	$828.70
B70B	Stroke and Other Cerebrovascular Disorders, Intermediate Complexity	$8,139.00	19	3	$868.90
B70C	Stroke and Other Cerebrovascular Disorders, Minor Complexity	$2,316.70	6	0	$803.20
B70D	Stroke and Other Cerebrovascular Disorders, Transferred <5 Days	$2,572.20	5	0	$1,194.50
B71A	Cranial and Peripheral Nerve Disorders, Major Complexity	$2,718.60	7	1	$825.30
B71B	Cranial and Peripheral Nerve Disorders, Minor Complexity	$735.80	4	0	$633.80
B72A	Nervous System Infection Except Viral Meningitis, Major Complexity	$9,061.80	21	3	$888.00
B72B	Nervous System Infection Except Viral Meningitis, Minor Complexity	$2,220.70	5	0	$926.30
B73Z	Viral Meningitis	$5,027.30	11	2	$917.30
B74A	Nontraumatic Stupor and Coma, Major Complexity	$8,062.90	20	3	$800.30
B74B	Nontraumatic Stupor and Coma, Minor Complexity	$2,033.30	5	0	$888.60
B75Z	Febrile Convulsions	$1,856.80	4	0	$1,319.30
B76A	Seizures, Major Complexity	$6,745.00	16	3	$846.70
B76B	Seizures, Minor Complexity	$2,843.40	6	0	$1,063.90
B77A	Headaches, Major Complexity	$4,356.60	10	2	$873.10
B77B	Headaches, Minor Complexity	$2,080.50	4	0	$915.20
B78A	Intracranial Injuries, Major Complexity	$14,639.40	33	5	$888.70
B78B	Intracranial Injuries, Minor Complexity	$4,091.60	10	2	$902.10
B78C	Intracranial Injuries, Transferred <5 Days	$2,162.10	4	0	$1,149.60
B79A	Skull Fractures, Major Complexity	$3,909.90	9	1	$870.00
B79B	Skull Fractures, Minor Complexity	$2,446.40	6	0	$831.60
B80A	Other Head Injuries, Major Complexity	$7,451.40	18	3	$865.30
B80B	Other Head Injuries, Minor Complexity	$2,119.20	5	0	$840.60
B81A	Other Disorders of the Nervous System, Major Complexity	$8,902.80	22	4	$810.60
B81B	Other Disorders of the Nervous System, Minor Complexity	$1,992.00	6	0	$744.70
B82A	Chronic and Unspec Para/Quadriplegia W or W/O OR Proc, Major Complexity	$29,810.30	35	10	$953.70
B82B	Chronic and Unspec Para/Quadriplegia W or W/O OR Proc, Intermediate Complexity	$7,230.40	16	3	$903.50
B82C	Chronic and Unspec Para/Quadriplegia W or W/O OR Proc, Minor Complexity	$2,772.50	5	0	$1,035.90
C01B	Procedures for Penetrating Eye Injury, Minor Complexity	$2,359.30	4	0	$965.80
C02Z	Enucleations and Orbital Procedures	$3,495.60	4	0	$1,446.20
C03A	Retinal Procedures, Major Complexity	$2,697.80	4	0	$1,206.40
C03B	Retinal Procedures, Minor Complexity	$993.30	4	0	$593.10
C04A	Major Corneal, Scleral and Conjunctival Procedures, Major Complexity	$3,303.00	4	0	$1,446.20
C04B	Major Corneal, Scleral and Conjunctival Procedures, Minor Complexity	$2,933.60	4	0	$1,446.20
C05Z	Dacryocystorhinostomy	$2,788.20	4	0	$1,369.60
C10Z	Strabismus Procedures	$2,005.90	4	0	$1,062.80

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
C11Z	Eyelid Procedures	$2,149.00	4	0	$1,115.50
C12Z	Other Corneal, Scleral and Conjunctival Procedures	$1,660.60	4	0	$1,003.50
C13Z	Lacrimal Procedures	$1,310.10	4	0	$673.00
C14A	Other Eye Procedures, Major Complexity	$1,669.80	4	0	$782.40
C14B	Other Eye Procedures, Minor Complexity	$1,442.70	4	0	$802.10
C15Z	Glaucoma and Complex Cataract Procedures	$2,339.10	4	0	$1,169.60
C16Z	Lens Procedures	$2,016.30	4	0	$1,446.20
C60A	Acute and Major Eye Infections, Major Complexity	$10,874.40	23	4	$982.60
C60B	Acute and Major Eye Infections, Minor Complexity	$4,754.30	10	2	$1,005.90
C61A	Neurological and Vascular Disorders of the Eye, Major Complexity	$5,121.50	11	2	$984.60
C61B	Neurological and Vascular Disorders of the Eye, Minor Complexity	$1,982.90	5	0	$927.60
C62A	Hyphaema and Medically Managed Trauma to the Eye, Major Complexity	$5,247.60	12	2	$908.40
C62B	Hyphaema and Medically Managed Trauma to the Eye, Minor Complexity	$2,567.30	5	0	$1,132.70
C63A	Other Disorders of the Eye, Major Complexity	$7,544.60	18	3	$867.70
C63B	Other Disorders of the Eye, Intermediate Complexity	$1,800.70	4	0	$1,016.20
C63C	Other Disorders of the Eye, Minor Complexity	$737.50	4	0	$563.60
D01Z	Cochlear Implant	$7,099.20	4	0	$1,446.20
D02A	Head and Neck Procedures, Major Complexity	$16,912.00	15	2	$1,446.20
D02B	Head and Neck Procedures, Intermediate Complexity	$10,541.40	8	1	$1,446.20
D02C	Head and Neck Procedures, Minor Complexity	$4,414.40	4	0	$1,446.20
D03Z	Surgical Repair for Cleft Lip and Palate Disorders	$4,948.90	4	0	$1,446.20
D04A	Maxillo Surgery, Major Complexity	$4,629.00	4	0	$1,446.20
D04B	Maxillo Surgery, Minor Complexity	$2,557.30	4	0	$1,446.20
D05Z	Parotid Gland Procedures	$6,415.00	4	0	$1,446.20
D06Z	Sinus and Complex Middle Ear Procedures	$3,796.00	4	0	$1,446.20
D10Z	Nasal Procedures	$2,805.10	4	0	$1,446.20
D11Z	Tonsillectomy and Adenoidectomy	$2,058.50	4	0	$1,446.20
D12A	Other Ear, Nose, Mouth and Throat Procedures, Major Complexity	$3,105.50	4	0	$1,433.00
D12B	Other Ear, Nose, Mouth and Throat Procedures, Minor Complexity	$2,327.20	4	0	$1,356.00
D13Z	Myringotomy W Tube Insertion	$1,407.20	4	0	$962.00
D14A	Mouth and Salivary Gland Procedures, Major Complexity	$1,938.30	4	0	$1,293.00
D14B	Mouth and Salivary Gland Procedures, Minor Complexity	$1,706.10	4	0	$1,115.30
D15Z	Mastoid Procedures	$5,562.90	4	0	$1,446.20
D40Z	Dental Extractions and Restorations	$1,296.80	4	0	$1,138.60
D60A	Ear, Nose, Mouth and Throat Malignancy, Major Complexity	$11,534.40	27	4	$851.70
D60B	Ear, Nose, Mouth and Throat Malignancy, Minor Complexity	$2,119.80	5	0	$697.00
D61A	Dysequilibrium, Major Complexity	$4,800.70	12	2	$858.20
D61B	Dysequilibrium, Minor Complexity	$2,690.70	6	0	$980.00
D62A	Epistaxis, Major Complexity	$5,832.80	12	2	$976.00
D62B	Epistaxis, Minor Complexity	$1,682.70	4	0	$949.10
D63A	Otitis Media and Upper Respiratory Infections, Major Complexity	$4,315.00	9	1	$967.60
D63B	Otitis Media and Upper Respiratory Infections, Minor Complexity	$2,105.10	5	0	$956.10
D64A	Laryngotracheitis and Epiglottitis, Major Complexity	$1,914.90	4	0	$1,386.00

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
D64B	Laryngotracheitis and Epiglottitis, Minor Complexity	$1,484.80	4	0	$1,048.40
D65A	Nasal Trauma and Deformity, Major Complexity	$5,488.70	14	2	$830.80
D65B	Nasal Trauma and Deformity, Minor Complexity	$1,381.90	4	0	$751.80
D66A	Other Ear, Nose, Mouth and Throat Disorders, Major Complexity	$2,781.40	6	0	$914.00
D66B	Other Ear, Nose, Mouth and Throat Disorders, Minor Complexity	$1,140.50	4	0	$822.60
D67A	Oral and Dental Disorders, Major Complexity	$4,792.30	11	2	$893.90
D67B	Oral and Dental Disorders, Minor Complexity	$1,386.80	4	0	$861.70
E01A	Major Chest Procedures, Major Complexity	$30,427.10	35	6	$1,446.20
E01B	Major Chest Procedures, Intermediate Complexity	$19,165.40	19	3	$1,446.20
E01C	Major Chest Procedures, Minor Complexity	$13,449.60	12	2	$1,446.20
E02A	Other Respiratory System OR Procedures, Major Complexity	$15,071.30	23	4	$1,227.10
E02B	Other Respiratory System OR Procedures, Intermediate Complexity	$4,539.60	4	0	$1,446.20
E02C	Other Respiratory System OR Procedures, Minor Complexity	$2,736.40	4	0	$1,446.20
E40A	Respiratory System Disorders W Ventilator Support, Major Complexity	$31,715.40	27	4	$1,446.20
E40B	Respiratory System Disorders W Ventilator Support, Minor Complexity	$20,723.20	18	3	$1,446.20
E41A	Respiratory System Disorders W Non-Invasive Ventilation, Major Complexity	$21,866.10	34	6	$1,285.30
E41B	Respiratory System Disorders W Non-Invasive Ventilation, Minor Complexity	$14,952.70	20	3	$1,446.20
E42A	Bronchoscopy, Major Complexity	$8,045.60	16	3	$971.10
E42B	Bronchoscopy, Minor Complexity	$2,024.50	4	0	$953.20
E60A	Cystic Fibrosis, Major Complexity	$10,874.30	18	3	$1,192.00
E61A	Pulmonary Embolism, Major Complexity	$7,958.00	16	3	$995.40
E61B	Pulmonary Embolism, Minor Complexity	$3,874.70	8	1	$1,098.50
E62A	Respiratory Infections and Inflammations, Major Complexity	$8,500.80	18	3	$961.10
E62B	Respiratory Infections and Inflammations, Minor Complexity	$4,320.10	9	1	$1,037.30
E63A	Sleep Apnoea, Major Complexity	$751.40	4	0	$713.50
E63B	Sleep Apnoea, Minor Complexity	$775.70	4	0	$761.90
E64A	Pulmonary Oedema and Respiratory Failure, Major Complexity	$9,455.30	21	3	$941.50
E64B	Pulmonary Oedema and Respiratory Failure, Minor Complexity	$4,255.60	8	1	$1,047.20
E65A	Chronic Obstructive Airways Disease, Major Complexity	$8,251.70	18	3	$922.90
E65B	Chronic Obstructive Airways Disease, Minor Complexity	$3,535.70	9	1	$862.40
E66A	Major Chest Trauma, Major Complexity	$8,888.60	20	3	$900.80
E66B	Major Chest Trauma, Minor Complexity	$3,401.90	8	1	$881.10
E67A	Respiratory Signs and Symptoms, Major Complexity	$4,267.60	8	1	$982.60
E67B	Respiratory Signs and Symptoms, Minor Complexity	$2,091.70	4	0	$1,137.30
E68A	Pneumothorax, Major Complexity	$5,912.00	13	2	$939.40
E68B	Pneumothorax, Minor Complexity	$3,062.60	6	0	$1,205.60
E69A	Bronchitis and Asthma, Major Complexity	$5,996.50	13	2	$943.80
E69B	Bronchitis and Asthma, Minor Complexity	$3,032.10	7	1	$973.90
E70A	Whooping Cough and Acute Bronchiolitis, Major Complexity	$6,454.70	11	2	$1,231.10
E70B	Whooping Cough and Acute Bronchiolitis, Minor Complexity	$3,466.70	5	0	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
E71A	Respiratory Neoplasms, Major Complexity	$10,218.20	24	4	$849.20
E71B	Respiratory Neoplasms, Minor Complexity	$2,863.40	10	2	$610.70
E73A	Pleural Effusion, Major Complexity	$10,838.00	25	4	$864.50
E73B	Pleural Effusion, Intermediate Complexity	$5,536.30	12	2	$967.60
E73C	Pleural Effusion, Minor Complexity	$2,479.60	5	0	$954.70
E74A	Interstitial Lung Disease, Major Complexity	$6,488.00	16	3	$841.80
E74B	Interstitial Lung Disease, Minor Complexity	$1,940.10	7	1	$544.00
E75A	Other Respiratory System Disorders, Major Complexity	$6,741.40	15	2	$920.70
E75B	Other Respiratory System Disorders, Minor Complexity	$3,440.30	7	1	$1,012.40
F01A	Implantation and Replacement of AICD, Total System, Major Complexity	$23,441.10	22	4	$1,446.20
F01B	Implantation and Replacement of AICD, Total System, Minor Complexity	$9,782.70	5	0	$1,446.20
F02Z	Other AICD Procedures	$7,717.10	5	0	$1,446.20
F03A	Cardiac Valve Procedures W CPB Pump W Invasive Cardiac Investigation, Major Comp	$51,410.60	35	6	$1,446.20
F03B	Cardiac Valve Procedures W CPB Pump W Invasive Cardiac Investigation, Minor Comp	$32,558.40	19	3	$1,446.20
F04A	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Major Comp	$49,143.90	35	6	$1,446.20
F04B	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Interm Comp	$35,352.70	22	4	$1,446.20
F04C	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Minor Comp	$24,387.00	12	2	$1,446.20
F05A	Coronary Bypass W Invasive Cardiac Investigation, Major Complexity	$48,793.40	35	6	$1,446.20
F05B	Coronary Bypass W Invasive Cardiac Investigation, Minor Complexity	$38,562.10	25	4	$1,446.20
F06A	Coronary Bypass W/O Invasive Cardiac Investigation, Major Complexity	$40,351.60	29	5	$1,446.20
F06B	Coronary Bypass W/O Invasive Cardiac Investigation, Minor Complexity	$30,603.30	19	3	$1,446.20
F07A	Other Cardiothoracic/Vascular Procedures W CPB Pump, Major Complexity	$55,224.60	35	6	$1,446.20
F07B	Other Cardiothoracic/Vascular Procedures W CPB Pump, Intermediate Complexity	$40,268.00	25	4	$1,446.20
F07C	Other Cardiothoracic/Vascular Procedures W CPB Pump, Minor Complexity	$33,870.40	20	3	$1,446.20
F08A	Major Reconstructive Vascular Procedures W/O CPB Pump, Major Complexity	$39,806.40	35	6	$1,446.20
F08B	Major Reconstructive Vascular Procedures W/O CPB Pump, Intermediate Complexity	$20,770.50	15	2	$1,446.20
F08C	Major Reconstructive Vascular Procedures W/O CPB Pump, Minor Complexity	$12,627.70	7	1	$1,446.20
F09A	Other Cardiothoracic Procedures W/O CPB Pump, Major Complexity	$27,042.10	28	5	$1,446.20
F09B	Other Cardiothoracic Procedures W/O CPB Pump, Intermediate Complexity	$16,494.80	12	2	$1,446.20
F09C	Other Cardiothoracic Procedures W/O CPB Pump, Minor Complexity	$10,539.00	6	0	$1,446.20
F10A	Interventional Coronary Procedures, Admitted for AMI, Major Complexity	$19,098.70	18	3	$1,446.20
F10B	Interventional Coronary Procedures, Admitted for AMI, Minor Complexity	$11,748.30	7	1	$1,446.20
F11A	Amputation, Except Upper Limb and Toe, for Circulatory Disorders, Major Comp	$47,688.10	35	13	$1,151.20
F11B	Amputation, Except Upper Limb and Toe, for Circulatory Disorders, Minor Comp	$25,425.90	35	6	$1,334.30
F12A	Implantation and Replacement of Pacemaker, Total System, Major Complexity	$14,352.90	17	3	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
F12B	Implantation and Replacement of Pacemaker, Total System, Minor Complexity	$7,522.00	5	0	$1,446.20
F13A	Amputation, Upper Limb and Toe, for Circulatory Disorders, Major Complexity	$27,175.30	35	7	$1,103.50
F13B	Amputation, Upper Limb and Toe, for Circulatory Disorders, Minor Complexity	$10,908.30	13	2	$1,436.10
F14A	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Major Complexity	$23,661.90	31	5	$1,384.80
F14B	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Interm Comp	$10,311.30	8	1	$1,446.20
F14C	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Minor Complexity	$6,491.30	4	0	$1,446.20
F15A	Interventional Coronary Procs, Not Adm for AMI, W Stent Implant, Major Comp	$16,905.90	15	2	$1,446.20
F15B	Interventional Coronary Procs, Not Adm for AMI, W Stent Implant, Minor Comp	$11,809.00	4	0	$1,446.20
F16A	Interventional Coronary Procs, Not Adm for AMI, W/O Stent Implant, Major Comp	$15,080.80	15	2	$1,446.20
F16B	Interventional Coronary Procs, Not Adm for AMI, W/O Stent Implant, Minor Comp	$9,636.80	4	0	$1,446.20
F17A	Insertion and Replacement of Pacemaker Generator, Major Complexity	$6,881.80	8	1	$1,446.20
F17B	Insertion and Replacement of Pacemaker Generator, Minor Complexity	$3,495.10	4	0	$1,446.20
F18A	Other Pacemaker Procedures, Major Complexity	$12,872.50	17	3	$1,396.30
F18B	Other Pacemaker Procedures, Minor Complexity	$5,337.70	4	0	$1,446.20
F19A	Trans-Vascular Percutaneous Cardiac Intervention, Major Complexity	$13,315.60	12	2	$1,446.20
F19B	Trans-Vascular Percutaneous Cardiac Intervention, Minor Complexity	$7,973.90	4	0	$1,446.20
F20Z	Vein Ligation and Stripping	$4,450.00	4	0	$1,446.20
F21A	Other Circulatory System OR Procedures, Major Complexity	$22,496.30	35	7	$1,033.30
F21B	Other Circulatory System OR Procedures, Intermediate Complexity	$7,705.20	12	2	$1,139.60
F21C	Other Circulatory System OR Procedures, Minor Complexity	$4,066.70	4	0	$1,446.20
F40A	Circulatory Disorders W Ventilator Support, Major Complexity	$33,332.90	35	6	$1,446.20
F40B	Circulatory Disorders W Ventilator Support, Minor Complexity	$17,604.30	11	2	$1,446.20
F41A	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves Proc, Major Comp	$11,539.20	15	2	$1,446.20
F41B	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves Proc, Minor Comp	$6,227.80	6	0	$1,446.20
F42A	Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves Proc, Major Comp	$9,097.10	9	1	$1,446.20
F42B	Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves Proc, Minor Comp	$5,179.70	4	0	$1,446.20
F43A	Circulatory Disorders W Non-Invasive Ventilation, Major Complexity	$24,938.70	35	6	$1,432.30
F43B	Circulatory Disorders W Non-Invasive Ventilation, Minor Complexity	$18,202.00	22	4	$1,446.20
F60A	Circulatory Dsrd, Adm for AMI W/O Invas Card Inves Proc	$2,985.60	8	1	$834.60
F60B	Circulatory Dsrd, Adm for AMI W/O Invas Card Inves Proc, Transf <5 Days	$2,947.70	4	0	$1,446.20
F61A	Infective Endocarditis, Major Complexity	$16,780.50	35	6	$879.50

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
F61B	Infective Endocarditis, Minor Complexity	$4,929.40	12	2	$831.10
F62A	Heart Failure and Shock, Major Complexity	$11,293.30	25	4	$918.30
F62B	Heart Failure and Shock, Minor Complexity	$5,917.20	12	2	$1,052.20
F62C	Heart Failure and Shock, Transferred <5 Days	$2,641.90	5	0	$1,216.90
F63A	Venous Thrombosis, Major Complexity	$6,169.60	14	2	$914.30
F63B	Venous Thrombosis, Minor Complexity	$3,190.40	7	1	$1,042.70
F64A	Skin Ulcers in Circulatory Disorders, Major Complexity	$14,751.70	34	6	$877.50
F64B	Skin Ulcers in Circulatory Disorders, Intermediate Complexity	$8,015.30	18	3	$928.00
F64C	Skin Ulcers in Circulatory Disorders, Minor Complexity	$5,001.30	11	2	$926.10
F65A	Peripheral Vascular Disorders, Major Complexity	$8,007.40	20	3	$820.10
F65B	Peripheral Vascular Disorders, Minor Complexity	$1,748.20	4	0	$817.30
F66A	Coronary Atherosclerosis, Major Complexity	$5,640.70	14	2	$838.00
F66B	Coronary Atherosclerosis, Minor Complexity	$610.90	4	0	$454.50
F67A	Hypertension, Major Complexity	$6,743.30	15	2	$915.00
F67B	Hypertension, Minor Complexity	$3,057.90	7	1	$990.80
F68A	Congenital Heart Disease, Major Complexity	$1,434.20	6	0	$492.50
F68B	Congenital Heart Disease, Minor Complexity	$812.50	4	0	$642.00
F69A	Valvular Disorders, Major Complexity	$5,240.80	12	2	$878.80
F69B	Valvular Disorders, Minor Complexity	$1,219.20	4	0	$717.50
F72A	Unstable Angina, Major Complexity	$5,843.00	13	2	$926.00
F72B	Unstable Angina, Minor Complexity	$1,777.10	4	0	$966.80
F73A	Syncope and Collapse, Major Complexity	$7,276.10	17	3	$879.20
F73B	Syncope and Collapse, Minor Complexity	$2,878.20	5	0	$1,002.90
F74A	Chest Pain, Major Complexity	$3,700.90	9	1	$876.30
F74B	Chest Pain, Minor Complexity	$1,600.40	4	0	$982.90
F75A	Other Circulatory Disorders, Major Complexity	$10,699.00	23	4	$954.30
F75B	Other Circulatory Disorders, Intermediate Complexity	$6,276.20	12	2	$1,094.00
F75C	Other Circulatory Disorders, Minor Complexity	$2,340.60	5	0	$1,036.30
F76A	Arrhythmia, Cardiac Arrest and Conduction Disorders, Major Complexity	$5,903.20	13	2	$931.70
F76B	Arrhythmia, Cardiac Arrest and Conduction Disorders, Minor Complexity	$1,669.00	4	0	$1,050.80
G01A	Rectal Resection, Major Complexity	$41,788.10	35	8	$1,446.20
G01B	Rectal Resection, Intermediate Complexity	$25,304.90	26	4	$1,446.20
G01C	Rectal Resection, Minor Complexity	$15,341.20	13	2	$1,446.20
G02A	Major Small and Large Bowel Procedures, Major Complexity	$36,106.70	35	8	$1,446.20
G02B	Major Small and Large Bowel Procedures, Intermediate Complexity	$17,432.00	18	3	$1,446.20
G02C	Major Small and Large Bowel Procedures, Minor Complexity	$9,176.80	8	1	$1,446.20
G03A	Stomach, Oesophageal and Duodenal Procedures, Major Complexity	$32,815.20	35	6	$1,446.20
G03B	Stomach, Oesophageal and Duodenal Procedures, Intermediate Complexity	$14,705.60	11	2	$1,446.20
G03C	Stomach, Oesophageal and Duodenal Procedures, Minor Complexity	$7,517.30	5	0	$1,446.20
G04A	Peritoneal Adhesiolysis, Major Complexity	$23,974.40	30	5	$1,446.20
G04B	Peritoneal Adhesiolysis, Intermediate Complexity	$9,849.60	9	1	$1,446.20
G04C	Peritoneal Adhesiolysis, Minor Complexity	$6,003.00	4	0	$1,446.20
G05A	Minor Small and Large Bowel Procedures, Major Complexity	$14,528.50	21	3	$1,322.40

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
G05B	Minor Small and Large Bowel Procedures, Minor Complexity	$6,571.80	8	1	$1,446.20
G07A	Appendicectomy, Major Complexity	$7,185.10	9	1	$1,392.90
G07B	Appendicectomy, Minor Complexity	$4,748.70	4	0	$1,446.20
G10A	Hernia Procedures, Major Complexity	$4,795.60	5	0	$1,446.20
G10B	Hernia Procedures, Minor Complexity	$3,424.50	4	0	$1,446.20
G11A	Anal and Stomal Procedures, Major Complexity	$3,605.80	6	0	$1,144.70
G11B	Anal and Stomal Procedures, Minor Complexity	$2,185.70	4	0	$1,386.40
G12A	Other Digestive System OR Procedures, Major Complexity	$21,574.50	35	6	$1,122.70
G12B	Other Digestive System OR Procedures, Intermediate Complexity	$8,509.80	14	2	$1,195.90
G12C	Other Digestive System OR Procedures, Minor Complexity	$3,372.10	4	0	$1,446.20
G46A	Complex Endoscopy, Major Complexity	$3,334.50	7	1	$1,053.20
G46B	Complex Endoscopy, Minor Complexity	$1,229.70	4	0	$1,123.40
G47A	Gastroscopy, Major Complexity	$6,913.90	15	2	$909.40
G47B	Gastroscopy, Intermediate Complexity	$1,573.40	4	0	$944.80
G47C	Gastroscopy, Minor Complexity	$857.30	4	0	$784.00
G48A	Colonoscopy, Major Complexity	$1,986.60	4	0	$1,000.40
G48B	Colonoscopy, Minor Complexity	$1,089.70	4	0	$1,021.20
G60A	Digestive Malignancy, Major Complexity	$7,769.30	19	3	$821.40
G60B	Digestive Malignancy, Minor Complexity	$2,389.60	8	1	$645.10
G61A	Gastrointestinal Haemorrhage, Major Complexity	$6,527.40	15	2	$875.20
G61B	Gastrointestinal Haemorrhage, Minor Complexity	$2,514.70	6	0	$931.40
G64A	Inflammatory Bowel Disease, Major Complexity	$3,883.80	8	1	$1,006.90
G64B	Inflammatory Bowel Disease, Minor Complexity	$579.20	4	0	$560.70
G65A	Gastrointestinal Obstruction, Major Complexity	$8,116.10	19	3	$882.30
G65B	Gastrointestinal Obstruction, Minor Complexity	$3,470.00	7	1	$1,023.00
G66A	Abdominal Pain and Mesenteric Adenitis, Major Complexity	$3,914.00	9	1	$882.00
G66B	Abdominal Pain and Mesenteric Adenitis, Minor Complexity	$2,013.50	4	0	$978.40
G67A	Oesophagitis and Gastroenteritis, Major Complexity	$6,029.60	13	2	$951.40
G67B	Oesophagitis and Gastroenteritis, Minor Complexity	$2,467.30	5	0	$998.30
G70A	Other Digestive System Disorders, Major Complexity	$4,784.80	11	2	$910.70
G70B	Other Digestive System Disorders, Minor Complexity	$1,891.60	4	0	$893.60
H01A	Pancreas, Liver and Shunt Procedures, Major Complexity	$39,136.00	35	7	$1,446.20
H01B	Pancreas, Liver and Shunt Procedures, Intermediate Complexity	$19,947.60	16	3	$1,446.20
H01C	Pancreas, Liver and Shunt Procedures, Minor Complexity	$9,910.50	6	0	$1,446.20
H02A	Major Biliary Tract Procedures, Major Complexity	$21,235.70	30	5	$1,302.90
H02B	Major Biliary Tract Procedures, Minor Complexity	$8,088.20	9	1	$1,446.20
H05A	Hepatobiliary Diagnostic Procedures, Major Complexity	$8,241.30	10	2	$1,446.20
H05B	Hepatobiliary Diagnostic Procedures, Minor Complexity	$3,455.20	4	0	$1,446.20
H06A	Other Hepatobiliary and Pancreas OR Procedures, Major Complexity	$17,530.80	34	6	$1,003.90
H06B	Other Hepatobiliary and Pancreas OR Procedures, Intermediate Complexity	$5,264.80	6	0	$1,446.20
H06C	Other Hepatobiliary and Pancreas OR Procedures, Minor Complexity	$4,719.80	4	0	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
H07A	Open Cholecystectomy, Major Complexity	$22,689.20	24	4	$1,446.20
H07B	Open Cholecystectomy, Intermediate Complexity	$13,787.70	14	2	$1,446.20
H07C	Open Cholecystectomy, Minor Complexity	$9,323.40	8	1	$1,446.20
H08A	Laparoscopic Cholecystectomy, Major Complexity	$8,925.40	9	1	$1,446.20
H08B	Laparoscopic Cholecystectomy, Minor Complexity	$4,957.10	4	0	$1,446.20
H40C	Endoscopic Procedures for Bleeding Oesophageal Varices, Minor Complexity	$2,103.20	4	0	$1,213.50
H43A	ERCP Procedures, Major Complexity	$12,333.80	25	4	$927.60
H43B	ERCP Procedures, Intermediate Complexity	$6,142.90	10	2	$1,103.20
H43C	ERCP Procedures, Minor Complexity	$3,515.40	4	0	$1,300.70
H60A	Cirrhosis and Alcoholic Hepatitis, Major Complexity	$12,714.10	27	4	$950.90
H60B	Cirrhosis and Alcoholic Hepatitis, Intermediate Complexity	$4,131.90	10	2	$859.90
H60C	Cirrhosis and Alcoholic Hepatitis, Minor Complexity	$1,035.40	4	0	$623.30
H61A	Malignancy of Hepatobiliary System and Pancreas, Major Complexity	$9,780.90	23	4	$852.30
H61B	Malignancy of Hepatobiliary System and Pancreas, Minor Complexity	$2,832.70	10	2	$571.70
H62A	Disorders of Pancreas, Except Malignancy, Major Complexity	$8,505.20	17	3	$1,005.10
H62B	Disorders of Pancreas, Except Malignancy, Minor Complexity	$2,527.50	5	0	$992.90
H63A	Other Disorders of Liver, Major Complexity	$8,181.50	19	3	$883.40
H63B	Other Disorders of Liver, Intermediate Complexity	$2,122.30	5	0	$987.20
H63C	Other Disorders of Liver, Minor Complexity	$1,173.30	4	0	$864.10
H64A	Disorders of the Biliary Tract, Major Complexity	$5,751.10	13	2	$924.00
H64B	Disorders of the Biliary Tract, Minor Complexity	$2,338.00	5	0	$1,028.20
I01A	Bilateral and Multiple Major Joint Procedures of Lower Limb, Major Complexity	$19,847.80	17	3	$1,446.20
I01B	Bilateral and Multiple Major Joint Procedures of Lower Limb, Minor Complexity	$15,555.40	10	2	$1,446.20
I02A	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Major Complexity	$52,418.20	35	14	$1,149.00
I02B	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Intermediate Complexity	$14,462.60	17	3	$1,446.20
I02C	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Minor Complexity	$5,336.60	4	0	$1,446.20
I03A	Hip Replacement, Major Complexity	$16,894.00	18	3	$1,446.20
I03B	Hip Replacement, Minor Complexity	$11,928.20	8	1	$1,446.20
I04A	Knee Replacement, Major Complexity	$14,271.80	15	2	$1,446.20
I04B	Knee Replacement, Minor Complexity	$11,441.40	8	1	$1,446.20
I05A	Other Joint Replacement, Major Complexity	$13,039.70	15	2	$1,446.20
I05B	Other Joint Replacement, Minor Complexity	$8,134.70	6	0	$1,446.20
I06Z	Spinal Fusion for Deformity	$25,101.90	18	3	$1,446.20
I07Z	Amputation	$26,185.20	35	7	$1,162.50
I08A	Other Hip and Femur Procedures, Major Complexity	$19,552.10	32	5	$1,180.80
I08B	Other Hip and Femur Procedures, Minor Complexity	$7,672.90	8	1	$1,446.20
I09A	Spinal Fusion, Major Complexity	$34,053.90	35	7	$1,446.20
I09B	Spinal Fusion, Intermediate Complexity	$18,737.90	16	3	$1,446.20
I09C	Spinal Fusion, Minor Complexity	$13,723.00	9	1	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
I10A	Other Back and Neck Procedures, Major Complexity	$12,815.00	16	3	$1,425.00
I10B	Other Back and Neck Procedures, Minor Complexity	$8,155.10	6	0	$1,446.20
I11Z	Limb Lengthening Procedures	$9,016.20	9	1	$1,446.20
I12A	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Major Complexity	$23,242.00	35	7	$1,031.20
I12B	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Intermediate Comp	$8,404.10	13	2	$1,160.40
I12C	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Minor Complexity	$4,389.60	5	0	$1,446.20
I13A	Humerus, Tibia, Fibula and Ankle Procedures, Major Complexity	$11,222.00	17	3	$1,250.20
I13B	Humerus, Tibia, Fibula and Ankle Procedures, Minor Complexity	$4,680.90	4	0	$1,446.20
I15A	Cranio-Facial Surgery, Major Complexity	$19,801.50	22	4	$1,446.20
I15B	Cranio-Facial Surgery, Minor Complexity	$8,887.70	9	1	$1,446.20
I16Z	Other Shoulder Procedures	$4,418.80	4	0	$1,446.20
I17A	Maxillo-Facial Surgery, Major Complexity	$5,736.30	4	0	$1,446.20
I17B	Maxillo-Facial Surgery, Minor Complexity	$3,524.20	4	0	$1,446.20
I18A	Other Knee Procedures, Major Complexity	$2,993.30	4	0	$1,413.60
I18B	Other Knee Procedures, Minor Complexity	$2,364.70	4	0	$1,446.20
I19A	Other Elbow and Forearm Procedures, Major Complexity	$8,146.60	13	2	$1,211.80
I19B	Other Elbow and Forearm Procedures, Minor Complexity	$3,536.10	4	0	$1,446.20
I20A	Other Foot Procedures, Major Complexity	$5,729.40	7	1	$1,446.20
I20B	Other Foot Procedures, Minor Complexity	$3,505.60	4	0	$1,446.20
I21Z	Local Excision and Removal of Internal Fixation Devices of Hip and Femur	$3,029.40	4	0	$1,446.20
I23A	Local Excision and Removal of Internal Fixation Device, Except Hip and Fmr, Maj Comp	$3,481.20	4	0	$1,446.20
I23B	Local Excision and Removal of Internal Fixation Device, Except Hip and Fmr, Minor Comp	$1,949.60	4	0	$1,229.80
I24A	Arthroscopy, Major Complexity	$3,275.00	4	0	$1,446.20
I24B	Arthroscopy, Minor Complexity	$2,366.80	4	0	$1,446.20
I25A	Bone and Joint Diagnostic Procedures Including Biopsy, Major Complexity	$9,595.60	23	4	$810.20
I25B	Bone and Joint Diagnostic Procedures Including Biopsy, Minor Complexity	$2,749.80	5	0	$1,049.10
I27A	Soft Tissue Procedures, Major Complexity	$9,259.10	16	3	$1,098.10
I27B	Soft Tissue Procedures, Minor Complexity	$2,991.70	4	0	$1,446.20
I28A	Other Musculoskeletal Procedures, Major Complexity	$14,934.80	34	6	$833.50
I28B	Other Musculoskeletal Procedures, Intermediate Complexity	$3,936.80	4	0	$1,446.20
I28C	Other Musculoskeletal Procedures, Minor Complexity	$2,850.30	4	0	$1,446.20
I29Z	Knee Reconstructions, and Revisions of Reconstructions	$4,194.30	4	0	$1,446.20
I30Z	Hand Procedures	$2,217.90	4	0	$1,294.90
I31A	Revision of Hip Replacement, Major Complexity	$33,304.80	35	8	$1,356.20
I31B	Revision of Hip Replacement, Intermediate Complexity	$20,118.40	20	3	$1,446.20
I31C	Revision of Hip Replacement, Minor Complexity	$14,411.80	11	2	$1,446.20
I32A	Revision of Knee Replacement, Major Complexity	$20,796.20	27	4	$1,415.00
I32B	Revision of Knee Replacement, Minor Complexity	$12,935.90	11	2	$1,446.20
I40Z	Infusions for Musculoskeletal Disorders, Sameday	$1,346.30	1	1	$N/A
I60Z	Femoral Shaft Fractures	$14,785.80	35	6	$845.70

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
I61A	Distal Femoral Fractures, Major Complexity	$24,226.80	35	10	$807.20
I61B	Distal Femoral Fractures, Minor Complexity	$14,243.00	35	6	$827.10
I63A	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh, Major Complexity	$10,232.80	26	4	$795.10
I63B	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh, Minor Complexity	$5,700.20	13	2	$924.70
I64A	Osteomyelitis, Major Complexity	$16,589.10	35	7	$829.50
I64B	Osteomyelitis, Minor Complexity	$9,379.70	23	4	$828.20
I65A	Musculoskeletal Malignant Neoplasms, Major Complexity	$15,266.50	35	6	$865.40
I65B	Musculoskeletal Malignant Neoplasms, Minor Complexity	$8,025.60	18	3	$920.30
I66A	Inflammatory Musculoskeletal Disorders, Major Complexity	$14,906.30	33	5	$898.10
I66B	Inflammatory Musculoskeletal Disorders, Intermediate Complexity	$8,535.70	17	3	$1,021.00
I66C	Inflammatory Musculoskeletal Disorders, Minor Complexity	$5,822.40	13	2	$923.50
I67A	Septic Arthritis, Major Complexity	$15,393.90	35	6	$811.30
I67B	Septic Arthritis, Minor Complexity	$7,254.80	18	3	$828.00
I68A	Non-surgical Spinal Disorders, Major Complexity	$10,959.30	26	4	$865.50
I68B	Non-surgical Spinal Disorders, Minor Complexity	$5,891.30	12	2	$955.80
I69A	Bone Diseases and Arthropathies, Major Complexity	$9,669.70	24	4	$805.60
I69B	Bone Diseases and Arthropathies, Minor Complexity	$7,619.20	18	3	$856.80
I71A	Other Musculotendinous Disorders, Major Complexity	$9,018.60	21	3	$861.10
I71B	Other Musculotendinous Disorders, Minor Complexity	$4,617.80	10	2	$890.50
I72A	Specific Musculotendinous Disorders, Major Complexity	$13,080.50	33	5	$813.30
I72B	Specific Musculotendinous Disorders, Minor Complexity	$7,316.50	17	3	$878.30
I73A	Aftercare of Musculoskeletal Implants or Prostheses, Major Complexity	$12,100.10	32	5	$772.30
I73B	Aftercare of Musculoskeletal Implants or Prostheses, Minor Complexity	$6,268.40	14	2	$880.60
I74A	Injuries to Forearm, Wrist, Hand and Foot, Major Complexity	$14,493.70	35	6	$834.80
I74B	Injuries to Forearm, Wrist, Hand and Foot, Minor Complexity	$5,277.10	12	2	$868.10
I75A	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Major Complexity	$17,087.40	35	7	$833.60
I75B	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Minor Complexity	$8,824.10	21	3	$873.80
I76A	Other Musculoskeletal Disorders, Major Complexity	$16,155.30	35	7	$815.40
I76B	Other Musculoskeletal Disorders, Intermediate Complexity	$11,058.00	25	4	$897.20
I76C	Other Musculoskeletal Disorders, Minor Complexity	$6,718.70	15	2	$915.10
I77A	Fractures of Pelvis, Major Complexity	$15,875.10	35	6	$859.20
I77B	Fractures of Pelvis, Minor Complexity	$10,935.60	24	4	$915.90
I78A	Fractures of Neck of Femur, Major Complexity	$16,737.70	35	7	$791.60
I78B	Fractures of Neck of Femur, Minor Complexity	$11,874.10	30	5	$809.00
I79A	Pathological Fractures, Major Complexity	$15,370.80	35	6	$804.00
I79B	Pathological Fractures, Minor Complexity	$9,502.60	22	4	$885.50
I80Z	Femoral Fractures, Transferred to Acute Facility <2 Days	$1,154.40	4	0	$1,152.50
I81Z	Musculoskeletal Injuries, Sameday	$295.50	1	1	N/A
I82Z	Other Sameday Treatment for Musculoskeletal Disorders	$418.30	1	1	N/A
J01A	Microvas Tiss Transf for Skin, Subcut Tiss and Breast Dsrds, Major Complexity	$38,839.60	27	4	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
J01B	Microvas Tiss Transf for Skin, Subcut Tiss and Breast Dsrds, Minor Complexity	$23,027.10	14	2	$1,446.20
J06A	Major Procedures for Breast Disorders, Major Complexity	$7,105.00	7	1	$1,446.20
J06B	Major Procedures for Breast Disorders, Minor Complexity	$4,928.30	4	0	$1,446.20
J07A	Minor Procedures for Breast Disorders, Major Complexity	$2,944.40	4	0	$1,446.20
J07B	Minor Procedures for Breast Disorders, Minor Complexity	$2,381.80	4	0	$1,441.90
J08A	Other Skin Grafts and Debridement Procedures, Major Complexity	$11,241.60	20	3	$1,043.10
J08B	Other Skin Grafts and Debridement Procedures, Intermediate Complexity	$4,045.20	5	0	$1,387.30
J08C	Other Skin Grafts and Debridement Procedures, Minor Complexity	$2,606.50	4	0	$1,358.60
J09Z	Perianal and Pilonidal Procedures	$2,362.30	4	0	$1,161.70
J10A	Plastic OR Procs for Skin, Subcutaneous Tissue and Breast Disorders, Major Comp	$3,752.60	4	0	$1,317.10
J10B	Plastic OR Procs for Skin, Subcutaneous Tissue and Breast Disorders, Minor Comp	$2,823.20	4	0	$1,340.10
J11A	Other Skin, Subcutaneous Tissue and Breast Procedures, Major Complexity	$2,241.70	4	0	$998.00
J11B	Other Skin, Subcutaneous Tissue and Breast Procedures, Minor Complexity	$1,636.70	4	0	$903.40
J12A	Lower Limb Procedures W Ulcer or Cellulitis, Major Complexity	$20,361.70	35	6	$1,063.80
J12B	Lower Limb Procedures W Ulcer or Cellulitis, Minor Complexity	$9,308.40	15	2	$1,167.20
J13A	Lower Limb Procedures W/O Ulcer or Cellulitis, Major Complexity	$7,651.90	14	2	$1,003.30
J13B	Lower Limb Procedures W/O Ulcer or Cellulitis, Minor Complexity	$3,480.90	5	0	$1,244.80
J14Z	Major Breast Reconstructions	$11,686.80	7	1	$1,446.20
J60A	Skin Ulcers, Major Complexity	$15,185.70	35	6	$863.20
J60B	Skin Ulcers, Intermediate Complexity	$8,697.70	19	3	$951.20
J60C	Skin Ulcers, Minor Complexity	$5,539.10	13	2	$856.50
J62A	Malignant Breast Disorders, Major Complexity	$6,910.20	18	3	$800.30
J62B	Malignant Breast Disorders, Minor Complexity	$843.50	5	0	$413.70
J63A	Non-Malignant Breast Disorders, Major Complexity	$2,549.70	6	0	$912.20
J63B	Non-Malignant Breast Disorders, Minor Complexity	$1,653.00	4	0	$896.90
J64A	Cellulitis, Major Complexity	$8,563.00	19	3	$923.30
J64B	Cellulitis, Minor Complexity	$3,836.60	8	1	$966.00
J65A	Trauma to Skin, Subcutaneous Tissue and Breast, Major Complexity	$8,439.50	20	3	$863.30
J65B	Trauma to Skin, Subcutaneous Tissue and Breast, Minor Complexity	$3,180.00	7	1	$910.10
J67A	Minor Skin Disorders, Major Complexity	$4,361.80	10	2	$858.20
J67B	Minor Skin Disorders, Minor Complexity	$1,438.80	4	0	$791.10
J68A	Major Skin Disorders, Major Complexity	$5,798.50	12	2	$978.60
J68B	Major Skin Disorders, Minor Complexity	$1,931.80	4	0	$980.70
J69A	Skin Malignancy, Major Complexity	$10,323.50	28	5	$742.70
J69B	Skin Malignancy, Intermediate Complexity	$3,480.90	11	2	$632.20
J69C	Skin Malignancy, Minor Complexity	$1,910.10	8	1	$493.00
K01A	OR Procedures for Diabetic Complications, Major Complexity	$42,429.60	35	11	$1,218.30
K01B	OR Procedures for Diabetic Complications, Intermediate Complexity	$25,907.40	35	6	$1,270.00
K01C	OR Procedures for Diabetic Complications, Minor Complexity	$12,823.60	17	3	$1,369.30
K02A	Pituitary Procedures, Major Complexity	$23,274.10	21	4	$1,446.20
K02B	Pituitary Procedures, Minor Complexity	$15,438.10	12	2	$1,446.20
K03Z	Adrenal Procedures	$9,848.70	6	0	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
K05A	Parathyroid Procedures, Major Complexity	$6,779.10	6	0	$1,446.20
K05B	Parathyroid Procedures, Minor Complexity	$4,569.20	4	0	$1,446.20
K06A	Thyroid Procedures, Major Complexity	$8,313.90	5	0	$1,446.20
K06B	Thyroid Procedures, Minor Complexity	$5,405.00	4	0	$1,446.20
K08Z	Thyroglossal Procedures	$3,878.10	4	0	$1,446.20
K09A	Other Endocrine, Nutritional and Metabolic OR Procedures, Major Complexity	$16,566.70	29	5	$1,085.80
K09B	Other Endocrine, Nutritional and Metabolic OR Procedures, Minor Complexity	$7,794.70	7	1	$1,446.20
K10A	Revisional and Open Bariatric Procedures, Major Complexity	$9,223.60	6	0	$1,446.20
K10B	Revisional and Open Bariatric Procedures, Minor Complexity	$7,259.80	4	0	$1,446.20
K11A	Major Laparoscopic Bariatric Procedures, Major Complexity	$8,166.70	5	0	$1,446.20
K11B	Major Laparoscopic Bariatric Procedures, Minor Complexity	$7,533.70	4	0	$1,446.20
K12A	Other Bariatric Procedures, Major Complexity	$4,837.20	4	0	$1,446.20
K12B	Other Bariatric Procedures, Minor Complexity	$2,098.60	4	0	$1,368.60
K13Z	Plastic OR Procedures for Endocrine, Nutritional and Metabolic Disorders	$8,020.50	7	1	$1,446.20
K40A	Endoscopic and Investigative Procedures for Metabolic Disorders, Major Comp	$6,539.30	14	2	$951.60
K40B	Endoscopic and Investigative Procedures for Metabolic Disorders, Minor Comp	$1,163.80	4	0	$1,076.00
K60A	Diabetes, Major Complexity	$10,692.00	23	4	$946.10
K60B	Diabetes, Minor Complexity	$5,008.10	11	2	$956.80
K61A	Severe Nutritional Disturbance, Major Complexity	$11,697.50	24	4	$976.90
K61B	Severe Nutritional Disturbance, Minor Complexity	$6,835.80	14	2	$1,019.30
K62A	Miscellaneous Metabolic Disorders, Major Complexity	$10,479.90	23	4	$933.50
K62B	Miscellaneous Metabolic Disorders, Intermediate Complexity	$5,063.60	10	2	$1,052.80
K62C	Miscellaneous Metabolic Disorders, Minor Complexity	$804.90	4	0	$643.30
K63A	Inborn Errors of Metabolism, Major Complexity	$3,397.20	9	1	$820.50
K63B	Inborn Errors of Metabolism, Minor Complexity	$716.20	4	0	$575.40
K64A	Endocrine Disorders, Major Complexity	$6,176.10	13	2	$967.10
K64B	Endocrine Disorders, Minor Complexity	$1,544.10	4	0	$824.60
L02A	Operative Insertion of Peritoneal Catheter for Dialysis, Major Complexity	$10,513.20	20	3	$1,038.40
L02B	Operative Insertion of Peritoneal Catheter for Dialysis, Minor Complexity	$3,405.30	4	0	$1,446.20
L03A	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Major Complexity	$26,959.80	27	4	$1,446.20
L03B	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Intermediate Complexity	$14,754.70	11	2	$1,446.20
L03C	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Minor Complexity	$9,145.40	6	0	$1,446.20
L04A	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Major Complexity	$19,233.40	29	5	$1,293.50
L04B	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Intermediate Comp	$6,026.00	6	0	$1,446.20
L04C	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Minor Complexity	$3,486.50	4	0	$1,446.20
L05A	Transurethral Prostatectomy for Urinary Disorder, Major Complexity	$10,745.30	17	3	$1,205.30

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
L05B	Transurethral Prostatectomy for Urinary Disorder, Minor Complexity	$5,517.90	5	0	$1,446.20
L06A	Minor Bladder Procedures, Major Complexity	$13,081.20	21	3	$1,222.50
L06B	Minor Bladder Procedures, Intermediate Complexity	$5,484.90	7	1	$1,432.80
L06C	Minor Bladder Procedures, Minor Complexity	$3,121.60	4	0	$1,446.20
L07A	Other Transurethral Procedures, Major Complexity	$5,480.40	9	1	$1,123.70
L07B	Other Transurethral Procedures, Minor Complexity	$2,343.30	4	0	$1,446.20
L08A	Urethral Procedures, Major Complexity	$3,835.40	5	0	$1,340.40
L08B	Urethral Procedures, Minor Complexity	$2,356.70	4	0	$1,446.20
L09A	Other Procedures for Kidney and Urinary Tract Disorders, Major Complexity	$25,441.60	35	8	$1,070.50
L09B	Other Procedures for Kidney and Urinary Tract Disorders, Intermediate Complexity	$9,447.40	13	2	$1,293.10
L09C	Other Procedures for Kidney and Urinary Tract Disorders, Minor Complexity	$3,330.40	4	0	$1,446.20
L40Z	Ureteroscopy	$2,378.00	4	0	$1,403.60
L41Z	Cystourethroscopy for Urinary Disorder, Sameday	$1,066.20	1	1	N/A
L42Z	ESW Lithotripsy	$3,083.10	4	0	$1,446.20
L60A	Kidney Failure, Major Complexity	$15,105.10	31	5	$964.50
L60B	Kidney Failure, Intermediate Complexity	$5,933.80	13	2	$964.00
L60C	Kidney Failure, Minor Complexity	$2,756.10	8	1	$717.60
L61Z	Haemodialysis	$442.80	4	0	$434.90
L62A	Kidney and Urinary Tract Neoplasms, Major Complexity	$9,365.60	25	4	$756.90
L62B	Kidney and Urinary Tract Neoplasms, Minor Complexity	$2,355.90	7	1	$730.00
L63A	Kidney and Urinary Tract Infections, Major Complexity	$8,195.30	18	3	$915.60
L63B	Kidney and Urinary Tract Infections, Minor Complexity	$3,858.80	8	1	$1,014.60
L64A	Urinary Stones and Obstruction, Major Complexity	$3,428.60	6	0	$1,082.50
L64B	Urinary Stones and Obstruction, Minor Complexity	$2,037.20	4	0	$1,176.60
L65A	Kidney and Urinary Tract Signs and Symptoms, Major Complexity	$7,478.50	17	3	$894.30
L65B	Kidney and Urinary Tract Signs and Symptoms, Minor Complexity	$1,984.90	5	0	$928.10
L66Z	Urethral Stricture	$1,778.90	4	0	$1,165.60
L67A	Other Kidney and Urinary Tract Disorders, Major Complexity	$4,511.20	10	2	$921.00
L67B	Other Kidney and Urinary Tract Disorders, Intermediate Complexity	$1,405.60	4	0	$864.50
L67C	Other Kidney and Urinary Tract Disorders, Minor Complexity	$448.00	4	0	$373.10
M01A	Major Male Pelvic Procedures, Major Complexity	$12,264.80	8	1	$1,446.20
M01B	Major Male Pelvic Procedures, Minor Complexity	$9,636.70	5	0	$1,446.20
M02A	Transurethral Prostatectomy for Reproductive System Disorder, Major Complexity	$8,711.20	12	2	$1,383.90
M02B	Transurethral Prostatectomy for Reproductive System Disorder, Minor Complexity	$5,132.80	5	0	$1,446.20
M03A	Penis Procedures, Major Complexity	$5,283.80	6	0	$1,446.20
M03B	Penis Procedures, Minor Complexity	$2,748.60	4	0	$1,446.20
M04Z	Testes Procedures	$2,406.50	4	0	$1,373.10
M05Z	Circumcision	$1,494.10	4	0	$1,090.40
M06A	Other Male Reproductive System OR Procedures, Major Complexity	$4,794.60	5	0	$1,389.10
M06B	Other Male Reproductive System OR Procedures, Minor Complexity	$3,269.90	4	0	$1,446.20

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
M40Z	Cystourethroscopy for Male Reproductive System Disorder, Sameday	$1,138.70	1	1	N/A
M60A	Male Reproductive System Malignancy, Major Complexity	$6,596.40	17	3	$785.40
M60B	Male Reproductive System Malignancy, Minor Complexity	$1,288.90	4	0	$827.40
M61A	Benign Prostatic Hypertrophy, Major Complexity	$5,010.50	12	2	$794.60
M61B	Benign Prostatic Hypertrophy, Minor Complexity	$1,432.50	4	0	$928.70
M62A	Male Reproductive System Inflammation, Major Complexity	$6,226.80	16	3	$811.90
M62B	Male Reproductive System Inflammation, Minor Complexity	$2,956.60	6	0	$996.40
M63Z	Male Sterilisation Procedures	$1,260.60	4	0	$1,013.10
M64A	Other Male Reproductive System Disorders, Major Complexity	$2,202.20	5	0	$807.00
M64B	Other Male Reproductive System Disorders, Minor Complexity	$1,241.50	4	0	$885.60
N01A	Pelvic Evisceration and Radical Vulvectomy, Major Complexity	$20,471.90	24	4	$1,446.20
N01B	Pelvic Evisceration and Radical Vulvectomy, Minor Complexity	$12,324.30	8	1	$1,446.20
N04A	Hysterectomy for Non-Malignancy, Major Complexity	$8,512.30	7	1	$1,446.20
N04B	Hysterectomy for Non-Malignancy, Minor Complexity	$6,833.90	5	0	$1,446.20
N05A	Oophorectomy and Complex Fallopian Tube Procedures for Non-Malignancy, Major Comp	$7,073.40	6	0	$1,446.20
N05B	Oophorectomy and Complex Fallopian Tube Procedures for Non-Malignancy, Minor Comp	$4,479.20	4	0	$1,446.20
N06A	Female Reproductive System Reconstructive Procedures, Major Complexity	$6,738.00	7	1	$1,446.20
N06B	Female Reproductive System Reconstructive Procedures, Minor Complexity	$4,864.90	5	0	$1,446.20
N07A	Other Uterus and Adnexa Procedures for Non-Malignancy, Major Complexity	$3,232.80	4	0	$1,446.20
N07B	Other Uterus and Adnexa Procedures for Non-Malignancy, Minor Complexity	$1,810.30	4	0	$1,190.20
N08Z	Endoscopic and Laparoscopic Procedures, Female Reproductive System	$3,296.70	4	0	$1,446.20
N09Z	Other Vagina, Cervix and Vulva Procedures	$1,607.40	4	0	$1,009.80
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy	$1,418.50	4	0	$1,105.90
N11A	Other Female Reproductive System OR Procedures, Major Complexity	$6,256.90	10	2	$1,168.20
N11B	Other Female Reproductive System OR Procedures, Minor Complexity	$670.20	4	0	$567.20
N12A	Uterus and Adnexa Procedures for Malignancy, Major Complexity	$18,577.40	17	3	$1,446.20
N12B	Uterus and Adnexa Procedures for Malignancy, Intermediate Complexity	$10,835.10	8	1	$1,446.20
N12C	Uterus and Adnexa Procedures for Malignancy, Minor Complexity	$7,070.40	5	0	$1,446.20
N60A	Female Reproductive System Malignancy, Major Complexity	$10,404.50	25	4	$841.00
N60B	Female Reproductive System Malignancy, Minor Complexity	$2,410.60	9	1	$548.30
N61A	Female Reproductive System Infections, Major Complexity	$4,666.20	10	2	$976.50
N61B	Female Reproductive System Infections, Minor Complexity	$2,391.80	5	0	$982.10
N62A	Menstrual and Other Female Reproductive System Disorders, Major Complexity	$2,671.90	6	0	$871.90

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
N62B	Menstrual and Other Female Reproductive System Disorders, Minor Complexity	$1,109.50	4	0	$731.40
O01A	Caesarean Delivery, Major Complexity	$10,865.60	15	2	$1,446.20
O01B	Caesarean Delivery, Intermediate Complexity	$8,699.70	11	2	$1,446.20
O01C	Caesarean Delivery, Minor Complexity	$8,018.80	9	1	$1,446.20
O02A	Vaginal Delivery W OR Procedures, Major Complexity	$9,305.30	12	2	$1,446.20
O02B	Vaginal Delivery W OR Procedures, Minor Complexity	$7,246.10	9	1	$1,446.20
O03A	Ectopic Pregnancy, Major Complexity	$3,906.30	4	0	$1,446.20
O03B	Ectopic Pregnancy, Minor Complexity	$2,954.20	4	0	$1,446.20
O04A	Postpartum and Post Abortion W OR Procedures, Major Complexity	$5,236.80	8	1	$1,305.70
O04B	Postpartum and Post Abortion W OR Procedures, Minor Complexity	$1,702.00	4	0	$1,204.80
O05Z	Abortion W OR Procedures	$1,287.20	4	0	$1,049.70
O60A	Vaginal Delivery, Major Complexity	$6,806.80	10	2	$1,425.40
O60B	Vaginal Delivery, Intermediate Complexity	$6,159.10	9	1	$1,446.20
O60C	Vaginal Delivery, Minor Complexity	$5,634.50	8	1	$1,446.20
O61A	Postpartum and Post Abortion W/O OR Procedures, Major Complexity	$4,313.20	10	2	$896.70
O61B	Postpartum and Post Abortion W/O OR Procedures, Minor Complexity	$2,404.80	5	0	$1,054.10
O63A	Abortion W/O OR Procedures, Major Complexity	$1,422.90	4	0	$950.70
O63B	Abortion W/O OR Procedures, Minor Complexity	$796.00	4	0	$673.10
O66A	Antenatal and Other Obstetric Admissions, Major Complexity	$2,376.70	5	0	$1,013.40
O66B	Antenatal and Other Obstetric Admissions, Minor Complexity	$710.90	4	0	$618.30
P03B	Neonate, AdmWt 1000-1499g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$42,460.20	35	6	$1,446.20
P04B	Neonate, AdmWt 1500-1999g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$53,967.70	35	13	$1,430.70
P05B	Neonate, AdmWt 2000-2499g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$33,002.70	35	8	$1,384.20
P06B	Neonate, AdmWt >=2500g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$15,493.80	24	4	$1,321.20
P60A	Neonate W/O Sig OR/Vent>=96hrs, Died/Transfer Acute Facility <5 Days, MajC	$2,400.90	4	0	$1,236.80
P60B	Neonate W/O Sig OR/Vent>=96hrs, Died/Transfer Acute Facility <5 Days, MinC	$1,194.00	4	0	$953.10
P63B	Neonate, AdmWt 1000-1249g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$5,646.00	12	2	$958.80
P64B	Neonate, AdmWt 1250-1499g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$24,528.20	35	9	$878.20
P65A	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Extreme Comp	$28,055.10	35	10	$908.30
P65B	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Major Complexity	$23,517.80	35	9	$908.60
P65C	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Intermediate Comp	$18,196.90	35	7	$888.30
P65D	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$15,035.30	34	6	$901.30

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
P66A	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Extreme Comp	$15,609.20	35	6	$831.20
P66B	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Major Complexity	$13,002.70	29	5	$899.80
P66C	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Intermediate Comp	$9,711.10	22	4	$892.60
P66D	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$3,980.20	10	2	$882.90
P67A	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Extr Comp	$12,326.60	30	5	$843.60
P67B	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Maj Comp	$7,567.40	20	3	$774.20
P67C	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Int Comp	$6,505.70	15	2	$890.50
P67D	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Min Comp	$5,058.00	13	2	$816.80
P68A	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Ext Comp	$7,209.70	13	2	$1,157.60
P68B	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Maj Comp	$4,160.30	8	1	$1,060.00
P68C	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Int Comp	$3,277.50	6	0	$1,098.60
P68D	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Min Comp	$1,356.60	6	0	$487.60
Q01B	Splenectomy, Minor Complexity	$11,469.70	9	1	$1,446.20
Q02A	Blood and Immune System Disorders W Other OR Procedures, Major Complexity	$16,077.40	24	4	$1,282.80
Q02B	Blood and Immune System Disorders W Other OR Procedures, Minor Complexity	$3,250.60	4	0	$1,446.20
Q60A	Reticuloendothelial and Immunity Disorders, Major Complexity	$4,070.40	9	1	$940.50
Q60B	Reticuloendothelial and Immunity Disorders, Minor Complexity	$662.80	4	0	$604.40
Q61A	Red Blood Cell Disorders, Major Complexity	$3,984.30	9	1	$907.50
Q61B	Red Blood Cell Disorders, Intermediate Complexity	$960.60	4	0	$802.80
Q61C	Red Blood Cell Disorders, Minor Complexity	$513.10	4	0	$509.80
Q62A	Coagulation Disorders, Major Complexity	$5,521.30	14	2	$828.40
Q62B	Coagulation Disorders, Minor Complexity	$868.00	4	0	$690.40
R01A	Lymphoma and Leukaemia W Major OR Procedures, Major Complexity	$26,004.00	30	5	$1,446.20
R01B	Lymphoma and Leukaemia W Major OR Procedures, Minor Complexity	$8,982.40	8	1	$1,446.20
R02A	Other Neoplastic Disorders W Major OR Procedures, Major Complexity	$22,892.30	21	3	$1,446.20
R02B	Other Neoplastic Disorders W Major OR Procedures, Intermediate Complexity	$12,064.50	11	2	$1,446.20
R02C	Other Neoplastic Disorders W Major OR Procedures, Minor Complexity	$7,389.00	6	0	$1,446.20
R03A	Lymphoma and Leukaemia W Other OR Procedures, Major Complexity	$29,566.30	35	9	$1,046.30
R03B	Lymphoma and Leukaemia W Other OR Procedures, Intermediate Complexity	$10,150.70	15	2	$1,368.20
R03C	Lymphoma and Leukaemia W Other OR Procedures, Minor Complexity	$3,169.10	4	0	$1,446.20
R04A	Other Neoplastic Disorders W Other OR Procedures, Major Complexity	$9,557.50	15	2	$1,196.40

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
R04B	Other Neoplastic Disorders W Other OR Procedures, Minor Complexity	$3,821.50	4	0	$1,446.20
R60A	Acute Leukaemia, Major Complexity	$18,204.70	35	6	$1,004.90
R60B	Acute Leukaemia, Minor Complexity	$1,718.50	5	0	$815.40
R61A	Lymphoma and Non-Acute Leukaemia, Major Complexity	$9,005.50	19	3	$943.90
R61B	Lymphoma and Non-Acute Leukaemia, Minor Complexity	$1,024.30	4	0	$742.40
R62A	Other Neoplastic Disorders, Major Complexity	$8,682.00	21	3	$854.60
R62B	Other Neoplastic Disorders, Intermediate Complexity	$2,582.90	10	2	$535.90
R62C	Other Neoplastic Disorders, Minor Complexity	$1,581.80	4	0	$863.50
R63Z	Chemotherapy	$584.90	4	0	$580.70
T01A	Infectious and Parasitic Diseases W OR Procedures, Major Complexity	$31,584.50	35	8	$1,297.20
T01B	Infectious and Parasitic Diseases W OR Procedures, Intermediate Complexity	$13,360.70	19	3	$1,302.40
T01C	Infectious and Parasitic Diseases W OR Procedures, Minor Complexity	$6,882.70	10	2	$1,295.10
T40Z	Infectious and Parasitic Diseases W Ventilator Support	$32,906.60	31	5	$1,446.20
T60A	Septicaemia, Major Complexity	$17,898.10	34	6	$1,049.40
T60B	Septicaemia, Intermediate Complexity	$9,418.60	18	3	$1,057.30
T60C	Septicaemia, Minor Complexity	$6,123.70	12	2	$1,056.10
T61A	Postoperative and Post-Traumatic Infections, Major Complexity	$8,622.00	19	3	$894.80
T61B	Postoperative and Post-Traumatic Infections, Minor Complexity	$4,008.70	9	1	$955.90
T62A	Fever of Unknown Origin, Major Complexity	$7,466.80	16	3	$943.60
T62B	Fever of Unknown Origin, Minor Complexity	$3,497.80	7	1	$1,041.30
T63A	Viral Illnesses, Major Complexity	$7,541.50	17	3	$898.60
T63B	Viral Illnesses, Minor Complexity	$3,861.40	8	1	$1,001.80
T64A	Other Infectious and Parasitic Diseases, Major Complexity	$13,557.90	30	5	$896.00
T64B	Other Infectious and Parasitic Diseases, Intermediate Complexity	$8,720.40	18	3	$977.10
T64C	Other Infectious and Parasitic Diseases, Minor Complexity	$4,374.10	9	1	$952.00
U40Z	Mental Health Treatment W ECT, Sameday	$465.60	1	1	N/A
U60A	Mental Health Treatment W/O ECT, Sameday, Major Complexity	$352.90	1	1	N/A
U60B	Mental Health Treatment W/O ECT, Sameday, Minor Complexity	$321.40	1	1	N/A
U61A	Schizophrenia Disorders, Major Complexity	$20,199.50	35	9	$736.80
U61B	Schizophrenia Disorders, Minor Complexity	$14,298.50	35	6	$818.80
U62A	Paranoia and Acute Psychotic Disorders, Major Complexity	$17,504.90	35	8	$772.50
U62B	Paranoia and Acute Psychotic Disorders, Minor Complexity	$13,090.80	31	5	$868.00
U63A	Major Affective Disorders, Major Complexity	$23,508.70	35	10	$789.20
U63B	Major Affective Disorders, Minor Complexity	$15,937.90	35	6	$827.10
U64A	Other Affective and Somatoform Disorders, Major Complexity	$17,318.60	35	7	$844.40
U64B	Other Affective and Somatoform Disorders, Minor Complexity	$13,194.40	32	5	$826.60
U65A	Anxiety Disorders, Major Complexity	$16,391.40	35	6	$844.50
U65B	Anxiety Disorders, Minor Complexity	$11,000.00	25	4	$889.20
U66A	Eating and Obsessive-Compulsive Disorders, Major Complexity	$27,456.70	35	10	$874.80
U66B	Eating and Obsessive-Compulsive Disorders, Minor Complexity	$18,953.50	35	7	$898.90

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
U67A	Personality Disorders and Acute Reactions, Major Complexity	$19,614.70	35	8	$843.90
U67B	Personality Disorders and Acute Reactions, Minor Complexity	$14,507.30	34	6	$869.90
U68A	Childhood Mental Disorders, Major Complexity	$16,332.50	35	6	$858.70
U68B	Childhood Mental Disorders, Minor Complexity	$14,488.30	35	6	$841.50
V60A	Alcohol Intoxication and Withdrawal, Major Complexity	$15,484.30	35	6	$827.70
V60B	Alcohol Intoxication and Withdrawal, Minor Complexity	$12,138.40	33	5	$755.20
V61A	Drug Intoxication and Withdrawal, Major Complexity	$13,931.10	35	6	$780.70
V61B	Drug Intoxication and Withdrawal, Minor Complexity	$13,052.70	35	6	$684.20
V62A	Alcohol Use and Dependence, Major Complexity	$16,994.80	35	7	$820.50
V62B	Alcohol Use and Dependence, Minor Complexity	$12,597.10	31	5	$838.80
V63Z	Opioid Use and Dependence	$12,938.60	31	5	$839.50
V64Z	Other Drug Use and Dependence	$13,421.80	34	6	$803.20
V65Z	Treatment for Alcohol Disorders, Sameday	$330.00	1	1	N/A
V66Z	Treatment for Drug Disorders, Sameday	$318.60	1	1	N/A
W02A	Hip, Femur and Lower Limb Procedures for Multiple Sig Trauma, Major Complexity	$33,794.20	35	8	$1,415.40
W02B	Hip, Femur and Lower Limb Procedures for Multiple Sig Trauma, Minor Complexity	$21,028.30	27	4	$1,446.20
W04B	Multiple Significant Trauma W Other OR Procedures, Minor Complexity	$13,323.90	17	3	$1,446.20
W60A	Multiple Sig Trauma, Died or Transferred to Acute Facility <5 Days, Major Comp	$2,542.60	4	0	$1,305.60
W60B	Multiple Sig Trauma, Died or Transferred to Acute Facility <5 Days, Minor Comp	$2,262.80	4	0	$1,446.20
W61A	Multiple Significant Trauma W/O OR Procedures, Major Complexity	$19,707.20	35	6	$1,102.20
W61B	Multiple Significant Trauma W/O OR Procedures, Minor Complexity	$3,962.30	8	1	$994.60
X02A	Microvascular Tissue Transfer and Skin Grafts for Injuries to Hand, Major Comp	$8,497.10	8	1	$1,391.20
X02B	Microvascular Tissue Transfer and Skin Grafts for Injuries to Hand, Minor Comp	$3,658.70	4	0	$1,266.10
X04A	Other Procedures for Injuries to Lower Limb, Major Complexity	$10,122.30	16	3	$1,135.10
X04B	Other Procedures for Injuries to Lower Limb, Minor Complexity	$3,480.70	4	0	$1,446.20
X05A	Other Procedures for Injuries to Hand, Major Complexity	$3,506.20	4	0	$1,173.40
X05B	Other Procedures for Injuries to Hand, Minor Complexity	$2,413.00	4	0	$1,017.40
X06A	Other Procedures for Other Injuries, Major Complexity	$11,421.50	16	3	$1,306.60
X06B	Other Procedures for Other Injuries, Intermediate Complexity	$6,173.60	7	1	$1,444.30
X06C	Other Procedures for Other Injuries, Minor Complexity	$3,389.20	4	0	$1,446.20
X07A	Skin Grafts for Injuries Excluding Hand, Major Complexity	$23,467.80	35	7	$997.90
X07B	Skin Grafts for Injuries Excluding Hand, Intermediate Complexity	$11,646.40	18	3	$1,162.30
X07C	Skin Grafts for Injuries Excluding Hand, Minor Complexity	$5,438.50	6	0	$1,439.20
X60A	Injuries, Major Complexity	$7,735.10	18	3	$861.00
X60B	Injuries, Minor Complexity	$2,626.70	6	0	$885.20
X61A	Allergic Reactions, Major Complexity	$3,972.20	7	1	$1,189.50
X61B	Allergic Reactions, Minor Complexity	$1,434.50	4	0	$1,028.10
X62A	Poisoning/Toxic Effects of Drugs and Other Substances, Major Complexity	$5,520.60	12	2	$932.30

Item No.	Description	Max Fee (excl. GST)	Upper Trim Point Days	Lower Trim Point Days	Max Per Day Rate (excl. GST)
X62B	Poisoning/Toxic Effects of Drugs and Other Substances, Minor Complexity	$2,679.70	5	0	$1,053.90
X63A	Sequelae of Treatment, Major Complexity	$5,756.70	13	2	$891.50
X63B	Sequelae of Treatment, Minor Complexity	$2,288.20	5	0	$894.60
X64A	Other Injuries, Poisonings and Toxic Effects, Major Complexity	$9,336.90	22	4	$878.40
X64B	Other Injuries, Poisonings and Toxic Effects, Minor Complexity	$3,822.40	9	1	$916.80
Y02B	Skin Grafts for Other Burns, Intermediate Complexity	$5,072.20	5	0	$1,446.20
Y02C	Skin Grafts for Other Burns, Minor Complexity	$3,790.80	4	0	$1,090.20
Y03A	Other OR Procedures for Other Burns, Major Complexity	$5,821.60	11	2	$899.30
Y03B	Other OR Procedures for Other Burns, Minor Complexity	$3,149.50	5	0	$1,188.40
Y61Z	Severe Burns	$3,195.10	13	2	$493.40
Y62A	Other Burns, Major Complexity	$7,863.40	16	3	$992.50
Y62B	Other Burns, Minor Complexity	$4,462.90	10	2	$890.80
Z01A	Other Contacts W Health Services W OR Procedures, Major Complexity	$5,189.70	6	0	$1,383.80
Z01B	Other Contacts W Health Services W OR Procedures, Minor Complexity	$2,089.70	4	0	$1,309.70
Z40Z	Other Contacts W Health Services W Endoscopy, Sameday	$906.20	1	1	N/A
Z61A	Signs and Symptoms, Major Complexity	$6,445.90	17	3	$795.30
Z61B	Signs and Symptoms, Intermediate Complexity	$3,153.10	7	1	$934.30
Z61C	Signs and Symptoms, Minor Complexity	$2,490.60	6	0	$913.80
Z63A	Other Follow Up After Surgery or Medical Care, Major Complexity	$5,980.50	18	3	$680.70
Z63B	Other Follow Up After Surgery or Medical Care, Minor Complexity	$1,234.50	6	0	$444.90
Z64A	Other Factors Influencing Health Status, Major Complexity	$2,961.10	8	1	$707.80
Z64B	Other Factors Influencing Health Status, Minor Complexity	$504.60	4	0	$369.50
Z65Z	Congenital Anomalies and Problems Arising from Neonatal Period	$1,828.20	8	1	$494.20
Z66Z	Sleep Disorders	$1,147.10	4	0	$840.50

Table 3

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

Item No.	Description	Max Fee (excl. GST)
SAME-DAY SERVICES DAY SURGERY FACILITY		
	Accommodation	
The band into which services fall will be determined in accordance with the Day Only Procedures Manual.		
PR410	Band 1: including gastrointestinal endoscopy, some minor surgical and non-surgical procedures not normally requiring anaesthetic.	$499.10
PR420	Band 2: including procedures other than Band 1 performed under local anaesthetic with no sedation. Theatre time less than 1 hour.	$594.10
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.	$693.90
PR440	Band 4: including procedures other than Band 1 performed under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.	$735.60
	Theatre Fee Bands	
The band into which services fall will be determined in accordance with the Group Accommodation and Theatre Banding Schedule produced by the Commonwealth Department of Veterans Affairs, as in force at time of service.		
Where more than 1 service is provided in a single theatre session, the theatre charge is?		
(a) the theatre charge for the service with the highest theatre charge; plus		
(b) 50% of the theatre charge for the service with the next highest theatre charge; plus		
(c) 30% of the theatre charge for each of the other services so provided.		

Item No.	Description	Max Fee (excl. GST)
PRT01	Theatre fee band: 1	$573.20
PRT02	Theatre fee band: 2	$731.50
PRT03	Theatre fee band: 3	$1,017.20
PRT04	Theatre fee band: 4	$1,471.40
PRT05	Theatre fee band: 5	$1,888.10
PRT06	Theatre fee band: 6	$2,486.40
PRT07	Theatre fee band: 7	$3,401.40
PRT08	Theatre fee band: 8	$3,630.30
PRT09	Theatre fee band: 9	$4,843.00
PRT10	Theatre fee band: 10	$6,339.80
PRT11	Theatre fee band: 11	$8,996.50
PRT12	Theatre fee band: 12	$9,659.60
PRT13	Theatre fee band: 13	$9,134.30
PRT1A	Theatre fee band: 1A	$286.50
PRT50	Theatre fee band: Dental minor	$541.80
PRT55	Theatre fee band: Dental major	$977.40
PRT9A	Theatre fee band: 9A	$4,222.30

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